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Health Information Technology for Economic and Clinical Health Act or HITECH Act System Interactions and Interface Control Document (ICD)

State Interfaces Only

DRAFT

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REVISION HISTORY

Version	Date	Organization/Point of Contact	Description of Changes
3.22	12/22/2010	OIS	Updated based on latest XSDs and detailed interface specifications for State interfaces.
4.0	1/24/2011	OIS	Updated based on new C-5 and D-17 XSDs.
4.01	2/2/2011	OIS	Updated based on latest C-5 and D-17 XSDs after review of initial XSDs. Added EH Meaningful Use Measures and CQMs.
4.02	2/14/11	OIS	Updated based on new D-17 XSD.
4.03	2/22/11	OIS	Updates based on new C-5 XSD and clarification on maximum values for fields on the C-5.
6.0	9/14/11	OIS	Updated registration scenario diagrams, error file formats, and includes detailed ICDs for each interface.
6.01	11/1/11	OIS	Added clarification to D-18 frequency and PaymentDate field.
6.1	11/14/11	OIS	Updated C-5, D-16 and D-18 interfaces based on new XSDs taking effect in Release 12.01 (January 2012).

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1 INTRODUCTION

This section introduces the High Level Technical Design Concept and Alternative Analysis for the Health Information Technology for Economic and Clinical Health (HITECH) Act implementation at the Centers for Medicare & Medicaid Services (CMS).

1.1 Document Purpose

This document describes the system interactions and interfaces necessary to support the HITECH incentive payment program.

CMS created this document during the Concept Phase of the Systems Lifecycle Framework. The purpose of the deliverable is to describe the essential system interactions and interfaces required for Phase I of the HITECH program. This document is intended to facilitate the transition from the Concept and Requirements phases into the Design and Development phases by describing the system interaction at a lower level of detail and the high level concept of operations for the interfaces.

However, this document is not intended to be a complete interface specification. This document is also not intended to replace change requests that are needed to initiate changes to existing systems. The format is a modification of the Interface Control Document (ICD) template from the CMS Investment Lifecycle Framework. CMS will need to develop a complete ICD during the design phase of the HITECH systems development projects.

The document is intended to reflect all of the possible interfaces that are necessary for the success of the HITECH program.

1.2 Document Scope

The scope of this document is to describe the fundamental interactions between the IT systems necessary to support the HITECH incentive payment program. This document also identifies the data elements that will pass between the systems.

The document does not describe further technical details such as file layouts, data transfer mechanisms, and security controls. Additionally, this document reflects CMS' understanding of the system interactions and interfaces as of the writing of this document. Further refinements to the regulations and requirements document may necessitate changes to this document.

1.3 Intended Audience

This primary audience for this document is the CMS and contractor teams that will design and develop the systems supporting HITECH. Additionally, the document is intended for the business owners and the HITECH Steering Committee as a vehicle for documenting the expectations of each system supporting the program.

1.4 Document Organization

The remainder of the document consists of the following sections:

Main Document

The goal of the main document is to describe the HITECH context and to describe the essential system interactions required to fulfill the program requirements.

Appendices

The appendices have definitions for the system interfaces required to support the system interactions described in the main document.

2 REFERENCED DOCUMENTS

The following documents are related to this deliverable:

- American Recovery and Reinvestment Act of 2009/Division B by United States Congress. Division B – Tax, Unemployment, Health, State Fiscal Relief, And Other Provisions, Title IV – Medicare and Medicaid Health Information Technology; Miscellaneous Medicare Provisions, Sec. 4001 – 4302;
- 42 CFR Parts 412, et al. Medicare and Medicaid Programs; Electronic Health Record Incentive Program; Proposed Rule
- 42 CFR Parts 412, 413, 422, and 495 Medicare and Medicaid Programs; Electronic Health Record Incentive Program; Final Rule
- HITECH Business Process Models from the Office of Information Services, Enterprise Architecture and Strategy Group.
- Requirements Documents from the Office of Information Services.
- High Level Technical Design Concept and Alternatives Analysis from the Office of Information Services.
- CMS Enterprise File Transfer (EFT) Infrastructure Standards
- CMS Enterprise Messaging Infrastructure Standards

2.1 Relationship to Requirements Document

This document is intended to supplement the HITECH Requirements Document and provide information to assist business owners and contractors with implementing the program. The foundation for developing the ICD was the Requirements Document. However, the ICD may differ from the Requirements Document for the following reasons:

1. **Timing:** Due to the short timelines for the HITECH program, the Office of Information Services created this ICD in parallel with the HITECH Requirements Document. The interface team made every attempt to synchronize the ICD with the Requirements. However, the lack of a requirements baseline prevented the interface team from achieving complete traceability. This version of the ICD removes the checklists for "Requirements" next to the data elements as the development teams are now responsible for tying directly back to requirements and instituting the requisite change orders as necessary.
2. **Focus.** The ICD provides additional design information that is not appropriate for the Requirements Document. For example, the ICD identifies data elements for file control that are not applicable during requirements definition.

3 BUSINESS BACKGROUND

Section 3 of the document describes the background for the HITECH project.

3.1 Business Drivers

On Feb. 17, 2009, President Obama signed the American Recovery and Reinvestment Act of 2009 (Recovery Act), a critical measure to stimulate the economy. Among other provisions, the new law provides major opportunities for the Department of Health and Human Services (DHHS), its partner agencies, and the States to improve the nation's health care through health information technology (HIT) by promoting the meaningful use of electronic health records (EHR) via incentives.

The HIT provisions of the Recovery Act are found primarily in Title XIII, Division A, Health Information Technology, and in Title IV of Division B, Medicare and Medicaid Health Information Technology. These titles together are cited as the Health Information Technology for Economic and Clinical Health Act or the HITECH Act.

Under Title IV, incentive payments are available for certain Medicare eligible professionals (EPs) and hospitals for becoming meaningful EHR users. In addition, under the Medicaid program, federal matching funds are available to States under the incentive program.

CMS is responsible for implementing the HITECH incentive payment provisions.

3.2 Business Purpose

The purpose of this project is to support the HIT provisions of ARRA Titles IV and XIII. The goal of these provisions is to promote the adoption of EHR technology and electronic exchange of health information to improve the quality and cost of health care in the United States.

Figure 1 shows a high level overview of HITECH stakeholders and major functions.

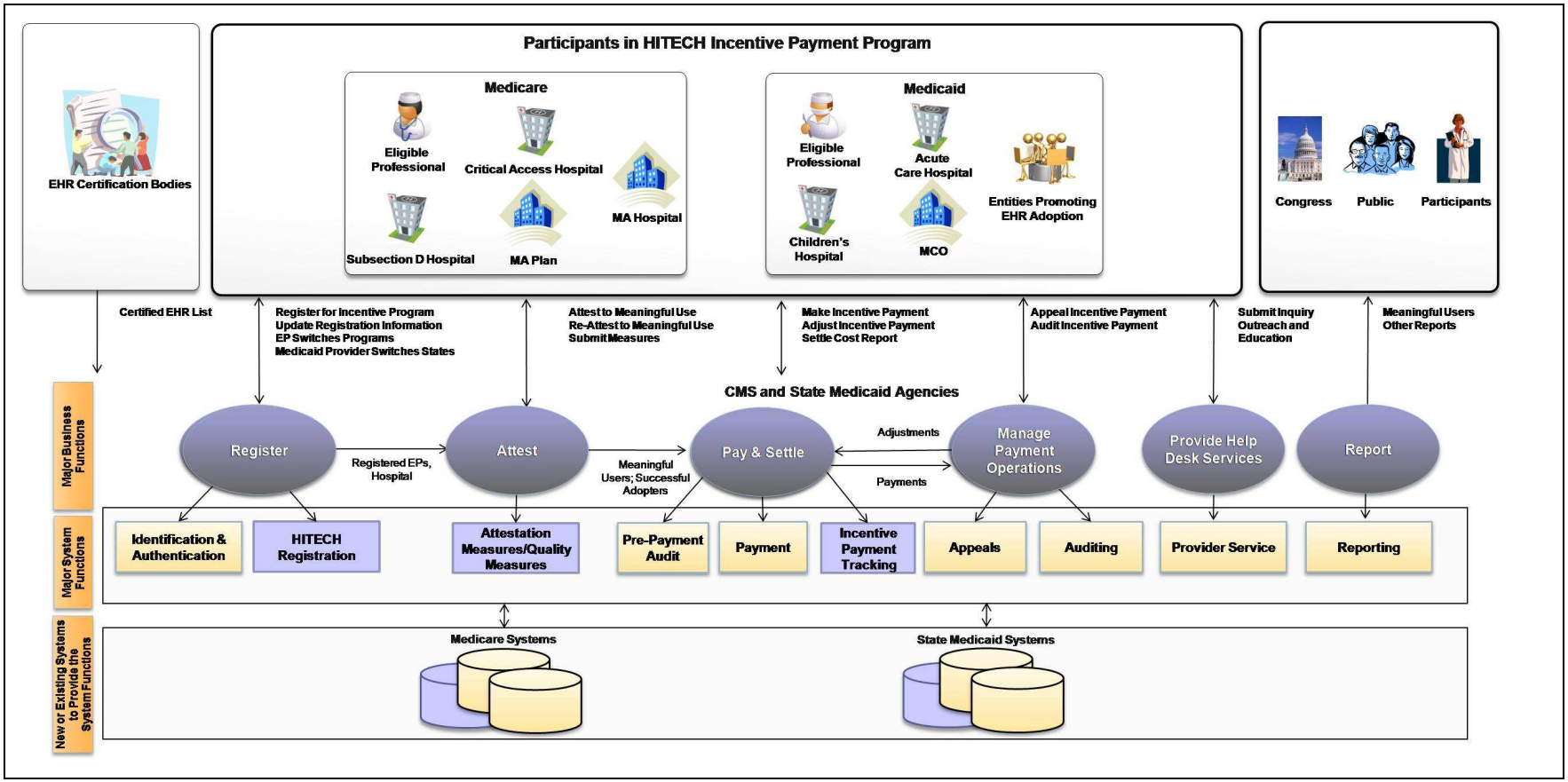

Figure 1: High Level HITECH Functions

3.3 Required Functionality

There are six major functions required for the HITECH program as illustrated in Figure 1.

Registration

CMS must provide a mechanism for Medicare and Medicaid EPs and Hospitals to register for the incentive payment program.

Attestation and Qualification

CMS and States must collect and analyze information from EPs and Hospitals to qualify them for the incentive payments. To qualify for payment, EPs and Hospital must demonstrate meaningful use of a certified EHR product, report clinical quality and other measures when CMS is prepared to accept them, and electronically exchange health information. In the first year of the program, CMS anticipates collecting attestations to demonstrate meaningful use. CMS will collect attestations from Medicare participants while States will collect attestations from Medicaid participants. Hospitals successfully attesting for Medicare will be deemed eligible for Medicaid if the hospital is Dually Eligible.

Payment and Settlement

After qualifying for payment, CMS and States must make incentive payments to hospitals and EPs (or the entities that EPs assigned payment – Medicare Advantage (MA) Plans, group practices, Medicaid Managed Care Organizations (MCOs), and Medicaid Entities promoting adoption of EHR). CMS will pay Medicare participants and States will pay Medicaid participants. CMS will provide funding to States through the Grants process.

Manage Post Payment Operations

Post payment, CMS and States will manage an appeals and auditing process. At the time of the publication of this document, CMS was still making policy decisions for appeals and auditing. This document assumes that the appeals function will allow program participants to dispute qualification and/or payment determinations. This document also assumes that the auditing function will implement pre and post payment controls to prevent and detect fraud, waste, and abuse.

Help Desk Service

The HITECH program will need help desk services to answer questions about the basic program rules (e.g., how to meet meaningful use), assist participants with submitting information to register and qualify for the program, and answer questions about actual incentive payments.

Reporting

The Recovery Act requires CMS to post the name and business address of Medicare eligible professionals and hospitals that received incentive payments to a public website. Additionally, CMS will need management reporting to manage the program and report program information to Congress and other stakeholders.

4 SYSTEMS OVERVIEW

To meet these business needs, CMS will need a combination of new systems and enhancements to existing systems. Figure 2 illustrates the high level systems concept for the HITECH program.

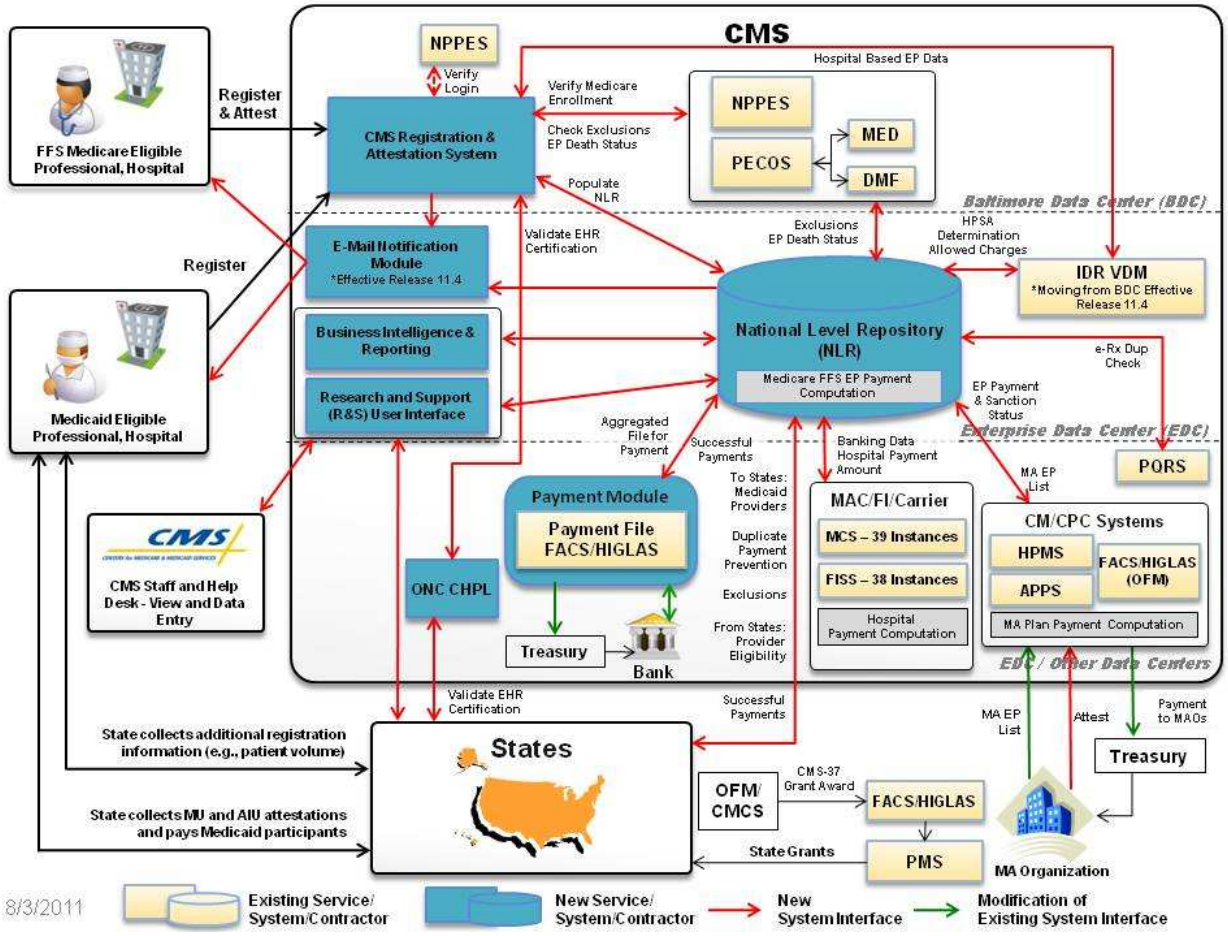

Figure 2: HITECH Systems Overview

CMS will leverage these existing systems:

- CMS will build a new Registration, a new Attestation Module, a new Inquiry Module, and a new Payment Module
- Provider Enrollment Chain and Ownership System (PECOS) will support validations of Medicare registrations using its database, the Death Master File (DMF), and Medicare Exclusion Database (MED).
- Health Plan Management System (HPMS) will accept bulk lists of Medicare Advantage EPs as prepared by the CM/CPC.New and existing CMS payment and accounting systems will support payment of Medicare participants
    - National Level Repository (NLR) to calculate Medicare EP payments and generate aggregated data for payment
    - Payment Module to make payments
    - Multi-Carrier System (MCS) to provide banking data for Eligible Professionals
    - Fiscal Intermediary Shared System (FISS) to provide banking data for hospitals
    - Financial Accounting System (FACS)
    - Healthcare Integrated General Ledger Accounting System (HIGLAS)
    - Automated Plan Payment System (APPS)
    - Provider Statistical & Reimbursement (PS&R) report system
    - Healthcare Cost Report Information System (HCRIS)
    - Physician Quality Reporting Systems (PQRS)
- Integrated Data Repository (IDR) will provide Part B claims history to identify hospital based physicians, make Health Professional Shortage Areas (HPSAs) determinations, and calculate allowed charges.
- Medicaid Budget & Expenditure System (MBES) will collect and track State program and administrative expenditures.

5 ASSUMPTIONS AND CONTRAINTS

Section 5 describes the assumptions and constraints that influence the system interactions and interfaces.

5.1 Assumptions

- Batch data interfaces will include a header and a trailer record on each file. The header and trailer will contain, at a minimum, the file name, number of records on the file, and a transmission date.
- The Requirements Document details the exception routines required for each interface. To avoid duplication, the ICD describes only the key exception condition in Section 10. The reader should refer to the Requirements Document for additional detail on exception handling.
- All receiving systems will send an automated response that indicates if the transfer was successful or unsuccessful.

5.2 Constraints

- The NLR will be capable of real time interfaces. However, several of the interfacing systems (e.g., FISS) are only capable of batch interfaces. The interface definitions only specify real time interface if both interfacing applications are real time capable.
- The Attestation interfaces in this document were completed after the Final Rule was published. The team made significant changes to the Attestation interfaces reflecting the final rule meaningful use definitions.
- The ICD does not define interface detail for the payment interfaces that are already well established with Treasury, banks, and the General Ledger systems.

6 GENERAL INTERFACE REQUIREMENTS

Section 6 provides an overview of the interfaces required the HITECH program. The remainder of the document provides additional system interaction and interface detail for registration, attestation, and payment. Table 1 describes the HITECH system interfaces.

The interfaces described in Table 1 and the appendices utilize the following conventions:

1. The "FROM" label in each of the interface descriptions indicates the system that initiates the transaction;
2. The "TO" label indicates the system that receives the transaction;
3. A "TO (with response)" label indicates that the receiving system responds to the initiating system with additional data;
4. Table 1 below is intended to contain all of the interfaces necessary for the HITECH program. However, the appendices only detail the interfaces that are new because of the HITECH program. Several of the payment interfaces already exist and have well defined interfaces that this document does not define (e.g., interfaces to Treasury);
5. Table 1 includes interfaces that were once identified, but deemed no longer necessary by business owners.

Table 1 - Overall Interface Matrix

#	Interfacing Applications	Purpose	Trigger /Frequency	Mode	Data Exchange Method	CMS Component with Oversight	Section / Appendix Reference
Interfaces Supporting Registration							
B-6	FROM: NLR TO: State	To inform the States of new, updated and cancelled Medicaid registrations. The NLR will send the States batch feeds of new EPs and Hospitals that signed up for HITECH and selected, or switched to, Medicaid.	Daily Starts 1/3/11	Batch	EFT – Connect:Direct Gentran CyberFusion	CMCS/ States, OIS/DND	Section 11.1
B-7	FROM: State TO: NLR	To update the NLR regarding the final eligibility of EPs and Hospitals that selected Medicaid. States will send the NLR the eligibility for each of the new, changed, or updated registrations.	Daily Starts 1/3/11	Batch	EFT – Connect:Direct Gentran CyberFusion	CMCS/ States, OIS/DND	Section 11.1

#	Interfacing Applications	Purpose	Trigger /Frequency	Mode	Data Exchange Method	CMS Component with Oversight	Section / Appendix Reference
Interfaces Supporting Attestation							
C-4	FROM: State TO: ONC CHPL (with ONC CHPL Response)	To verify that an EHR Certification Number provided by a Medicaid provider is valid.	Prior to Medicaid EHR Incentive Payment	Real-Time	Web Service	CMCS/States, ONC	Section 12.1
C-5	FROM: NLR TO: State	To send States attestation information submitted by Dually Eligible Hospitals via the CMS Attestation Module.	Daily Starts 4/4/11	Batch	EFT – Connect:Direct Gentran CyberFusion	CMCS/ States, OIS/DND	Section 12.2
Interfaces Supporting Payment							
D-16	FROM: State TO: NLR (with NLR response)	To prevent duplicate EHR incentive payments for EP providers between Medicare and Medicaid or, for EPs and EHs, between multiple Medicaid states.	Daily Starts 1/3/11	Batch	EFT – Connect:Direct Gentran CyberFusion	CMCS/ States, OIS/DND	Section 13.1

#	Interfacing Applications	Purpose	Trigger /Frequency	Mode	Data Exchange Method	CMS Component with Oversight	Section / Appendix Reference
D-17	FROM: NLR TO: State	To send States the cost report data elements utilized by CMS to determine Medicare hospital payments for Dually Eligible hospitals deemed eligible for the Medicaid HITECH incentive payment. The state will receive the cost report after a Dually Eligible hospital successfully attests for Medicare and the cost information is retrieved from the Shared Systems. The Medicare cost report is for information only to the states as an aid to use in computing the Medicaid payments.	Monthly Starts 4/4/11	Batch	EFT – Connect:Direct Gentran CyberFusion	CMCS/ States, OIS/DND	Section 13.1
D-18	FROM: State TO: NLR	To update NLR records as soon as payment is made indicating successful incentive payments for Medicaid EPs and Medicaid and Dually Eligible hospitals.	Daily Starts 1/3/11	Batch	EFT – Connect:Direct Gentran CyberFusion	CMCS/ States, OIS/DND	Section 13.1

6.1 System Responsibilities

Section 6.1 describes the general responsibilities of each application participating in an interface supporting the HITECH program.

6.1.1 Sending System Responsibilities

The sending system and its supporting contractors are responsible for:

- Communicating with the receiving system using agreed upon protocols.
- Sending all data required.
- Sending data in the agreed upon format.
- Accepting and displaying any messages coming from the receiving system.
- Sending and receiving messages for any transmission errors.
- Maintaining an audit trail to demonstrate the date and time of transactions.

6.1.2 Receiving System Responsibilities

The receiving system and its supporting contractors are responsible for:

- Communicating with the sending system using agreed upon protocols.
- Sending confirmation as required.
- Sending and receiving messages for any transmission errors.
- Verifying and validating any data as required and returning appropriate message.
- Storing data as required.
- Interpreting and displaying any messages contained in the returning data.
- Maintaining an audit trail to demonstrate date and time of receipt and response, as appropriate.

7 REGISTRATION SYSTEM INTERACTIONS

Section 7 describes the interactions necessary to fulfill the registration requirements of the HITECH program.

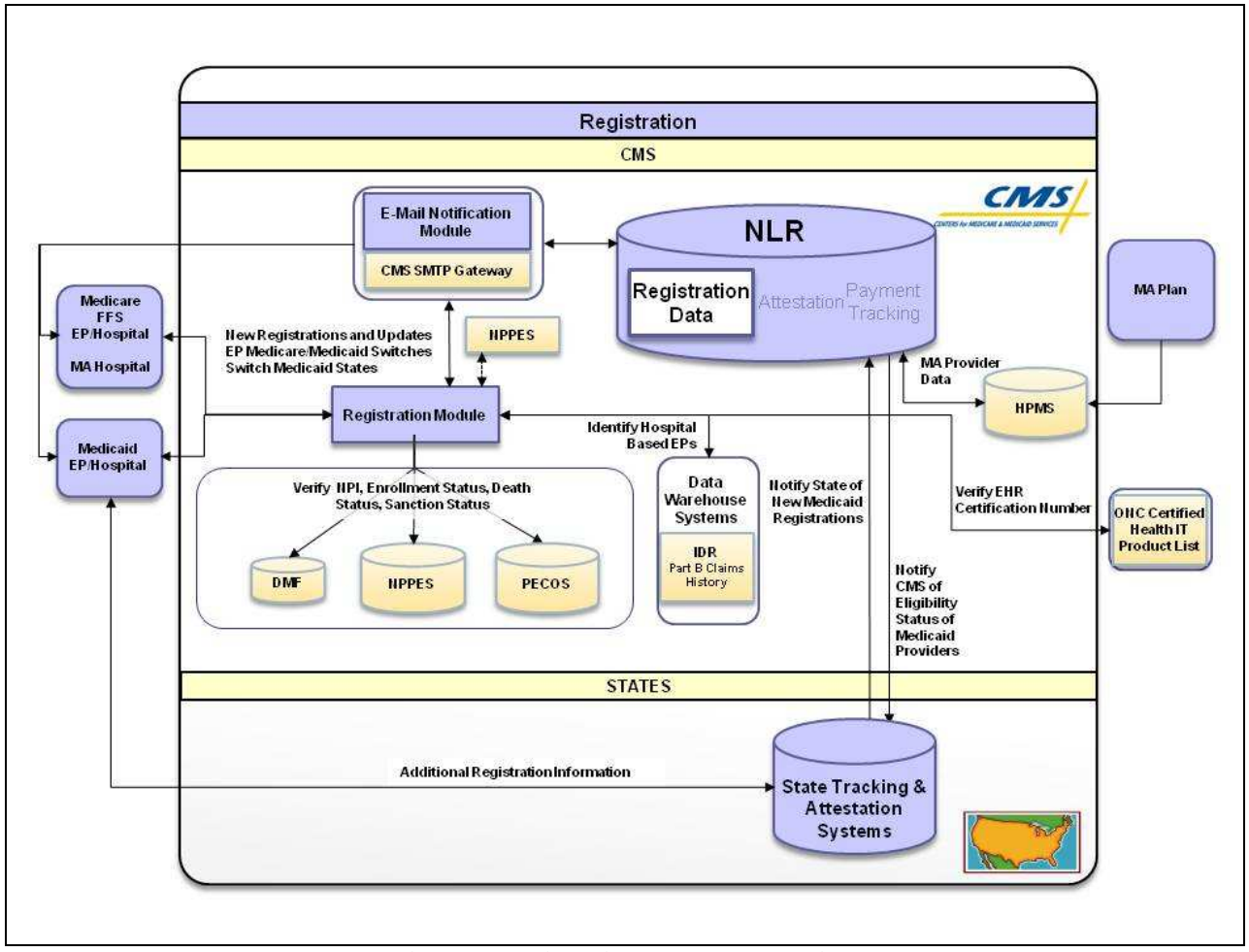

Figure 3: Registration System Interactions

7.1 Hospital Registration Scenarios and Interfaces

7.1.1 Scenario 1: Register Medicare/Medicaid Eligible Hospital

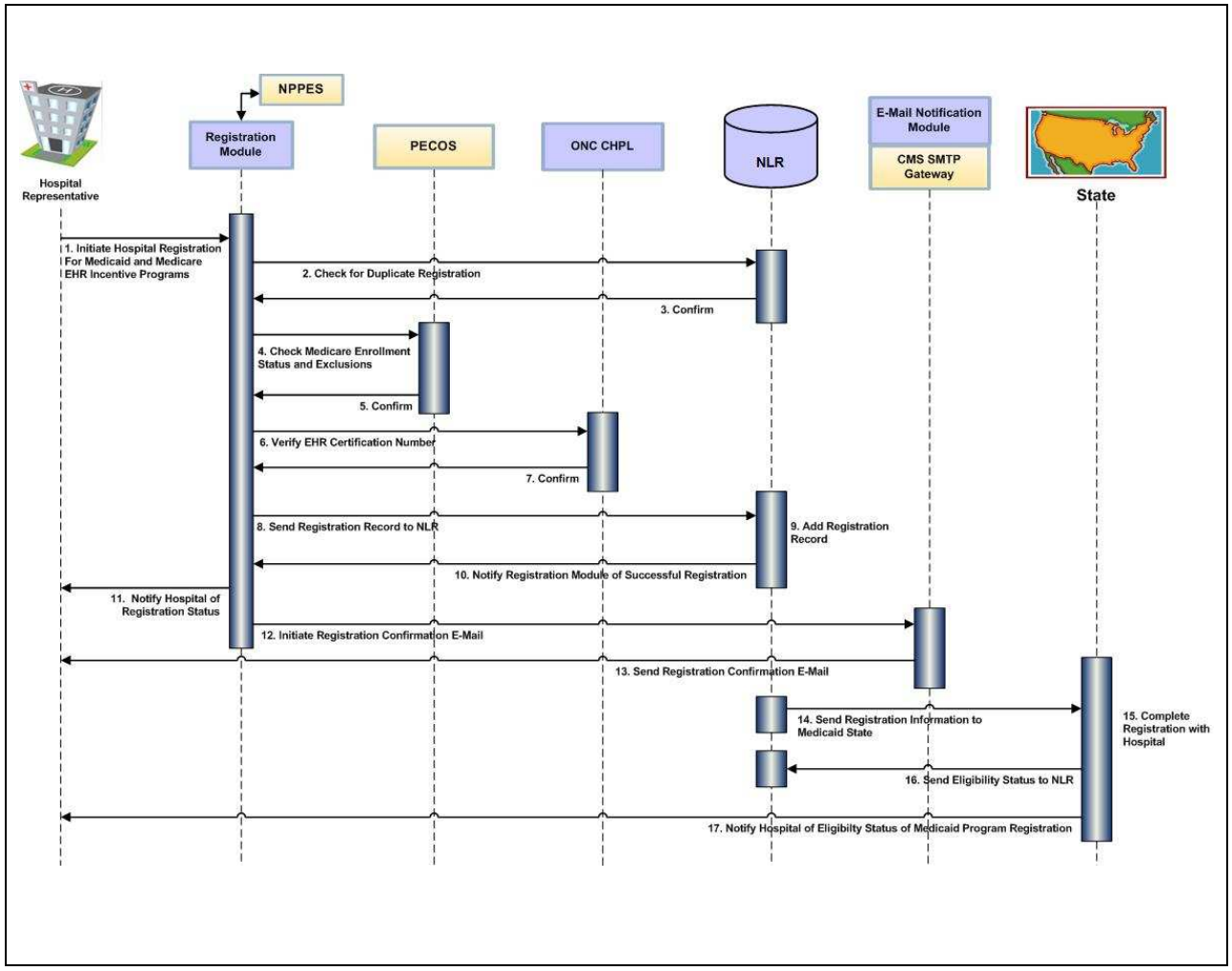

Figure 4: Scenario 1 - Register Medicare/Medicaid Eligible Hospital

The registration process requires the Registration Module and NLR to orchestrate several interfaces to determine if the Hospital is eligible to register for the HITECH program. Before writing a registration record, the Registration Module and NLR must complete interfaces to verify the NPI and Medicare provider status. Once the NLR has stored the registration record, it is passed on to the State system to complete the Medicaid registration process if the Hospital is registering for both Medicare and Medicaid.

The following interfaces, described in the appendix, support Scenario 1:

- Interface B-2 (A,B): Registration Module – NPPES for NPI verification
- Interface B-3 (A,B,C): Registration Module – PECOS for Medicare provider verification
- Interface B-1 (A,B): Registration Module – NLR to write registration record to NLR database
- Interface B-6: NLR – State to pass provider registration data to the Medicaid State
- Interface B-7: State – NLR for Medicaid State to confirm registration with CMS
- Interface B-9: Registration Module – E-Mail Notification Module to send registration confirmation e-mail (effective Release 11.04)
- Interface B-10: Registration Module – ONC CHPL to confirm validity of EHR Certification Number

7.2 Medicaid Registration Scenarios and Interfaces

This subsection describes the interfaces necessary for registration of Medicaid EPs and the data elements that will flow between the systems. The intent of the sequence diagrams is to model the flow between the systems and to highlight the system behavior in basic HITECH interactions. This section illustrates sequence diagrams for the following scenarios.

- Register Medicaid EP
- Switch EP between Programs
- Switch Medicaid EP between States

7.2.1 Scenario 2: Register Medicaid Eligible Professional

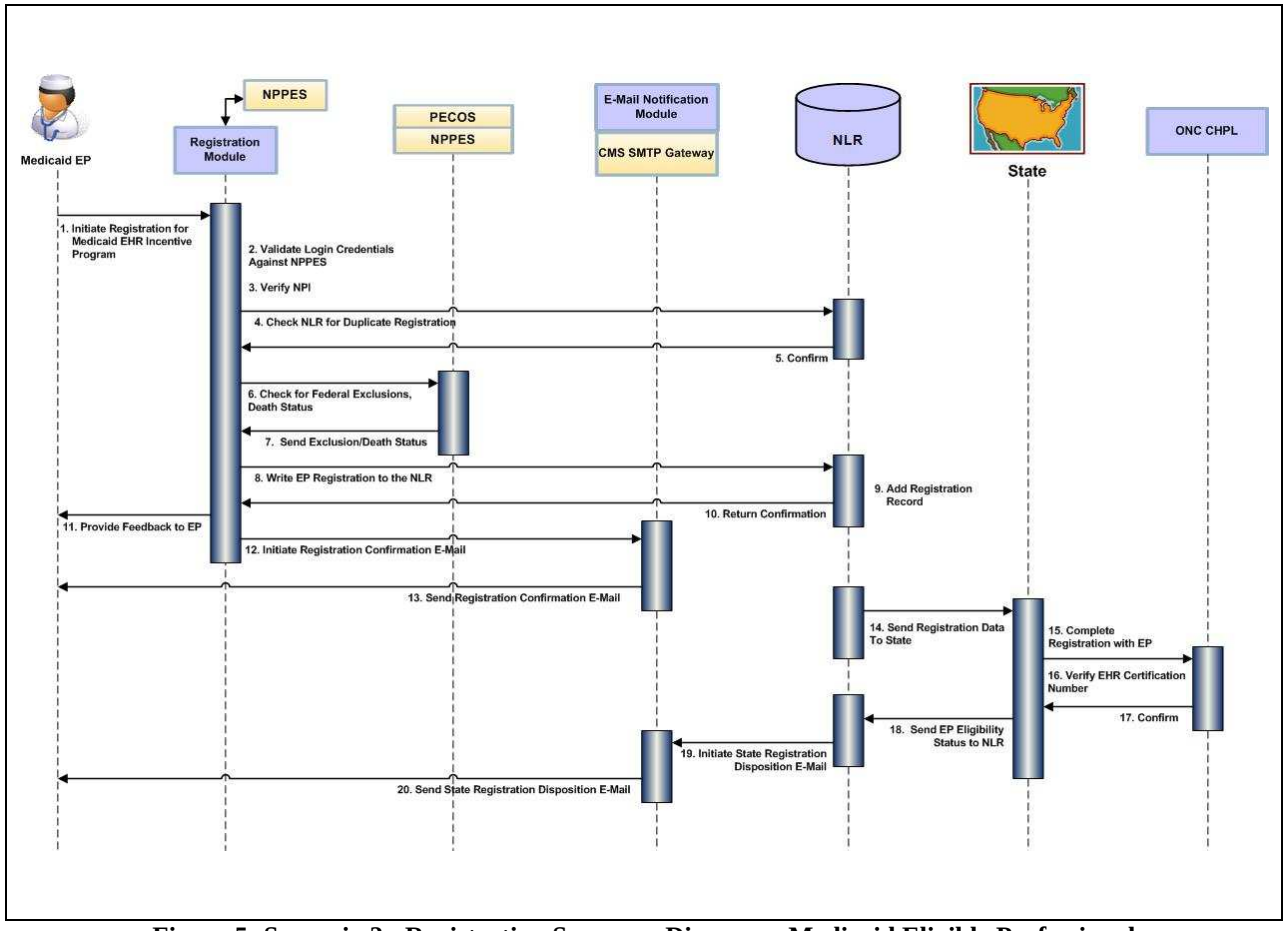

Figure 5: Scenario 2 - Registration Sequence Diagram - Medicaid Eligible Professional

Medicaid EPs will register in the CMS Registration Module. The Registration Module and NLR must orchestrate several interfaces to support this process. First, the Registration Module must interface with NPPES to verify the NPI. Second, the Registration Module must interface with DMF and PECOS to determine the death status and any Federal exclusions of the Medicaid EP. Third, the Registration Module and NLR must interface to write a new record to the NLR's transactional database. Finally, the NLR must interface with the State to exchange registration information.

The following interfaces, described in the appendix, support Scenario 2:

- Interface B-2 (A,B): Registration Module – NPPES to verify the NPI of the Medicaid EP
- Interface B-2 (A,B,C): Registration Module – PECOS to determine exclusion status of Medicaid EPs if the EP is also a Medicare provider
- Interface B-4: Registration Module – NPPES to determine death status of Medicaid EPs
- Interface B-1 (A,B): Registration Module – NLR to write records to the NLR transactional database
- Interface B-6: NLR – States to send registration data to States
- Interface B-7: States – NLR for States to confirm registration with CMS
- Interface B-9: Registration Module – E-Mail Notification Module to send registration confirmation e-mail (effective Release 11.04)
- Interface C-4: States – ONC CHPL to confirm validity of EHR Certification Number

7.2.2 Scenario 3: Switch Eligible Professional between Programs

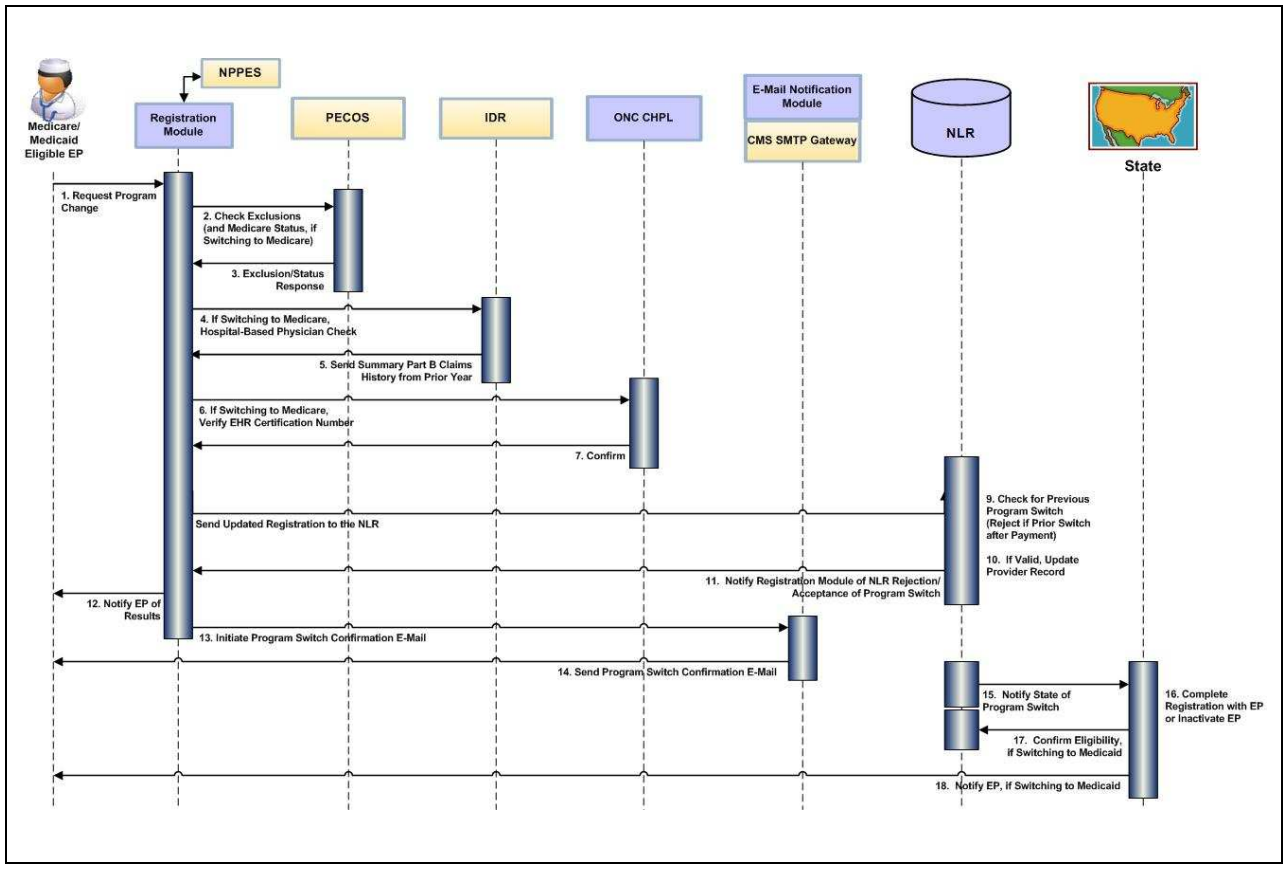

Figure 6: Scenario 3 - Registration Sequence Diagram - Switch between Programs

Scenario 3 applies to both Medicare and Medicaid when an EP switches between programs. Prior to the first payment, EPs can switch between programs as many times as desired. After the first payment, an EP can only switch between programs once. During this process, the Registration Module must utilize interfaces to determine the Medicare provider status of Medicaid EPs switching to Medicare and exchange information with the relevant State.

The following interfaces, described in the appendix, support Scenario 3:

- Interface B-2 (A,B,C): Registration Module – PECOS for Medicaid EPs switching to Medicare
- Interface B-5: Registration Module – IDR to determine hospital-based providers for Medicaid EPs switching to Medicare
- Interface B-6: NLR – States to send EP registration data to States

- Interface B-7: States – NLR for States to confirm registration with CMS
- Interface B-9: Registration Module – E-Mail Notification Module to send registration confirmation e-mail (effective Release 11.04)
- Interface B-10: Registration Module – ONC CHPL to confirm validity of EHR Certification Number for Medicaid EPs switching to Medicare

7.2.3 Scenario 4: Switch Eligible Professional between States

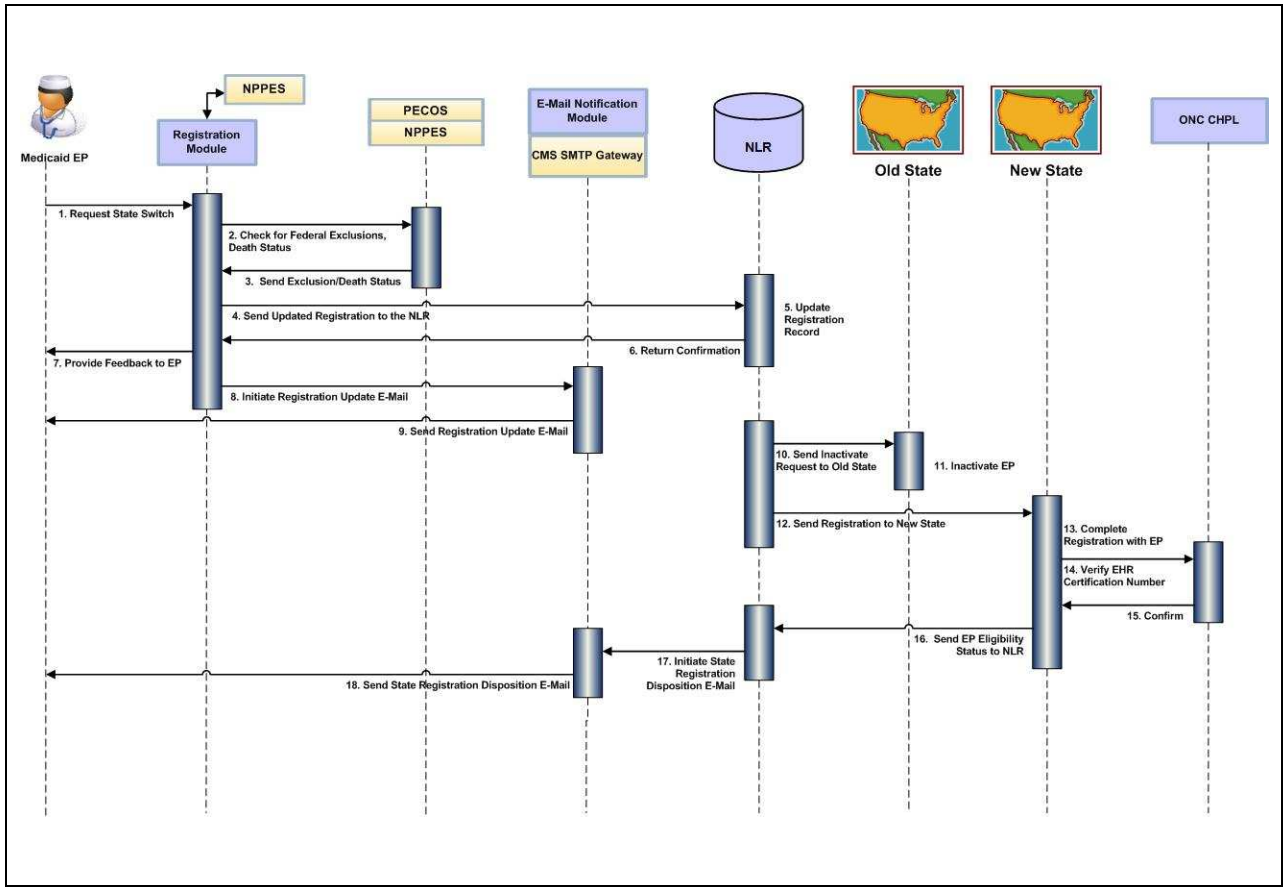

Figure 7: Scenario 4 - Registration Sequence Diagram - Switch Eligible Professional between States

Medicaid EPs can switch between States utilizing the CMS Registration Module. The Registration Module and NLR must orchestrate several interfaces to support this business process. First, the Registration Module and NLR must interface to update the registration record in the NLR transactional database. Second, the NLR must exchange information with the "old" State and the "new" State.

The following interfaces, described in the appendix, support Scenario 4:

- Interface B-1 (A,B): Registration Module – NLR to update registration record
- Interface B-2 (A,B,C): Registration Module – PECOS to determine exclusion status of Medicaid EPs if the EP is also a Medicare provider
- Interface B-4: Registration Module – NPPES to determine death status of Medicaid EPs

- Interface B-6: NLR – States to send requests to the new and old State
- Interface B-7: States – NLR for the new State to confirm the action
- Interface B-9: Registration Module – E-Mail Notification Module to send registration confirmation e-mail (effective Release 11.04)
- Interface C-4: States – ONC CHPL to confirm validity of EHR Certification Number

8 ATTESTATON SYSTEM INTERACTIONS AND INTERFACES

Section 8 describes the attestation system interactions and interfaces.

8.1 Attestation System Interactions

Subsection 8.1 describes the systems interaction required to fulfill the attestation requirements.

8.1.1 High Level Attestation System Interactions

Figure 10 illustrates the high level system interactions for attestation.

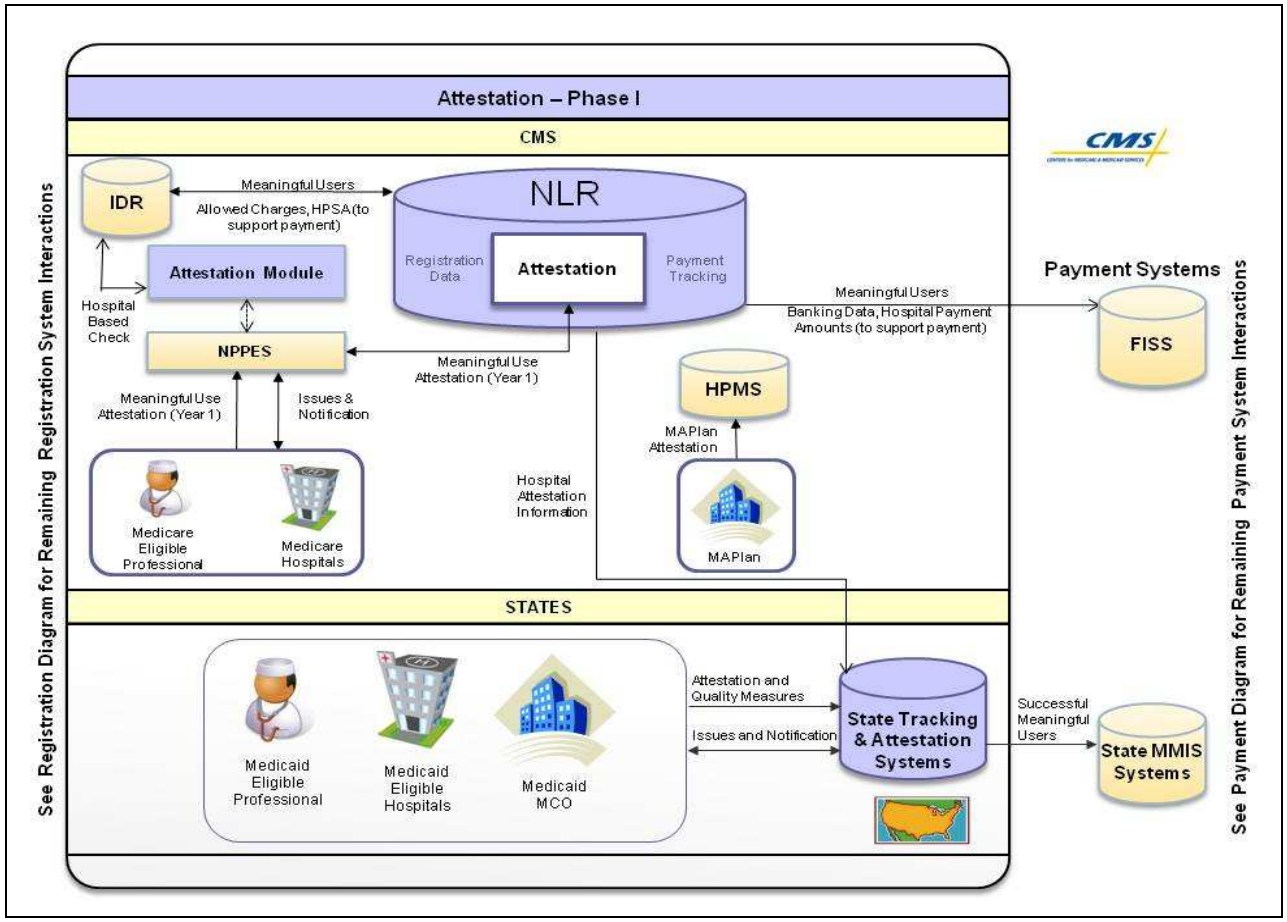

Figure 8: High Level Attestation System Interactions

8.2 Attestation Scenarios and Interfaces

This document illustrates sequence diagrams for the following scenarios. The intent of these sequence diagrams is to model the flow between the systems and to highlight the system behavior in basic HITECH interactions.

8.2.1 Scenario 5: Medicare Eligible Professional and Dually Eligible Hospital Attestation

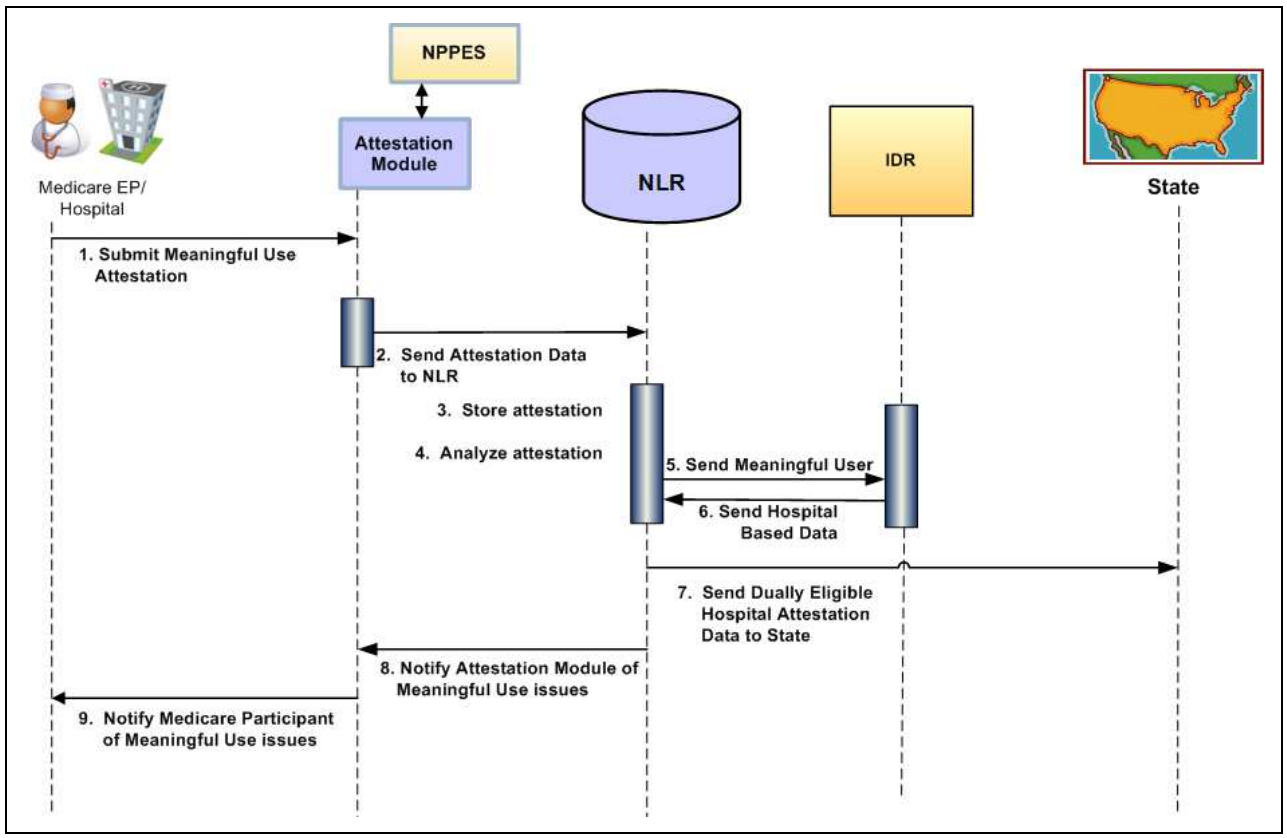

Figure 9: Scenario 5 - Attestation Sequence

Medicare EPs submit meaningful use attestations via the Attestation Module. The Attestation Module and the NLR will interface to write attestation records to the NLR transactional database. The Attestation Module will interface with the IDR to check the EPs hospital based data prior to qualifying the EP for payment. The final interface is for the NLR to send attestation data for Dually Eligible hospitals to the State.

The following interfaces, described in the appendix, support Scenario 5:

- Interface C-2: Attestation Module – NLR to write Medicare and Dually Eligible hospital attestation data to the NLR database
- Interface C-3: Attestation Module – NLR to write Medicare EP attestation data to the NLR database
- Interface C-1: Attestation Module - IDR to determine hospital-based physician status (repeated and the same as Interface B-5)
- Interface C-4: States – ONC CHPL to confirm validity of EHR Certification Number
- Interface C-5: NLR – State to send attestation information for Dually Eligible hospitals

9 PAYMENT SYSTEM INTERACTIONS AND INTERFACES

Section 9 describes the payment system interactions and interfaces.

9.1 Payment System Interactions

Subsection 9.1 describes the systems interaction required to fulfill the payment requirements.

9.1.1 High Level Payment System Interactions

Figure 13 illustrates the high level system interactions for payment.

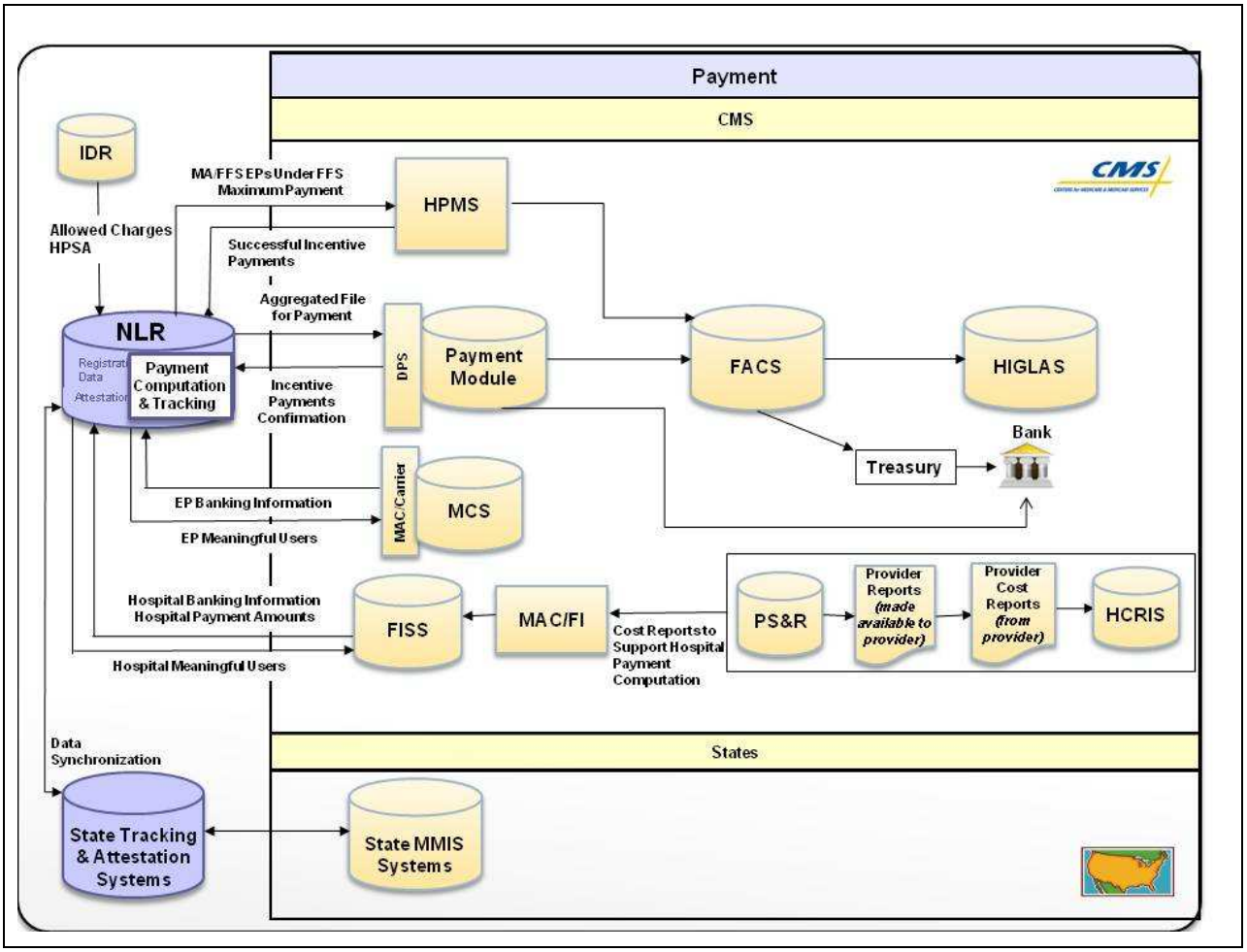

Figure 10: High Level Payment System Interaction

9.2 Medicaid EP and Hospital Payment Scenarios and Interfaces

This subsection describes the interfaces necessary for Medicaid EP payment and the data elements that will flow between the systems. The intent of the sequence diagrams is to model the flow between the systems and to highlight the system behavior in basic HITECH interactions. This section illustrates sequence diagrams for the following scenarios.

- Medicaid EP Payments
- Medicaid Hospital Payments

9.2.1 Scenario 6: Medicaid EP Payments

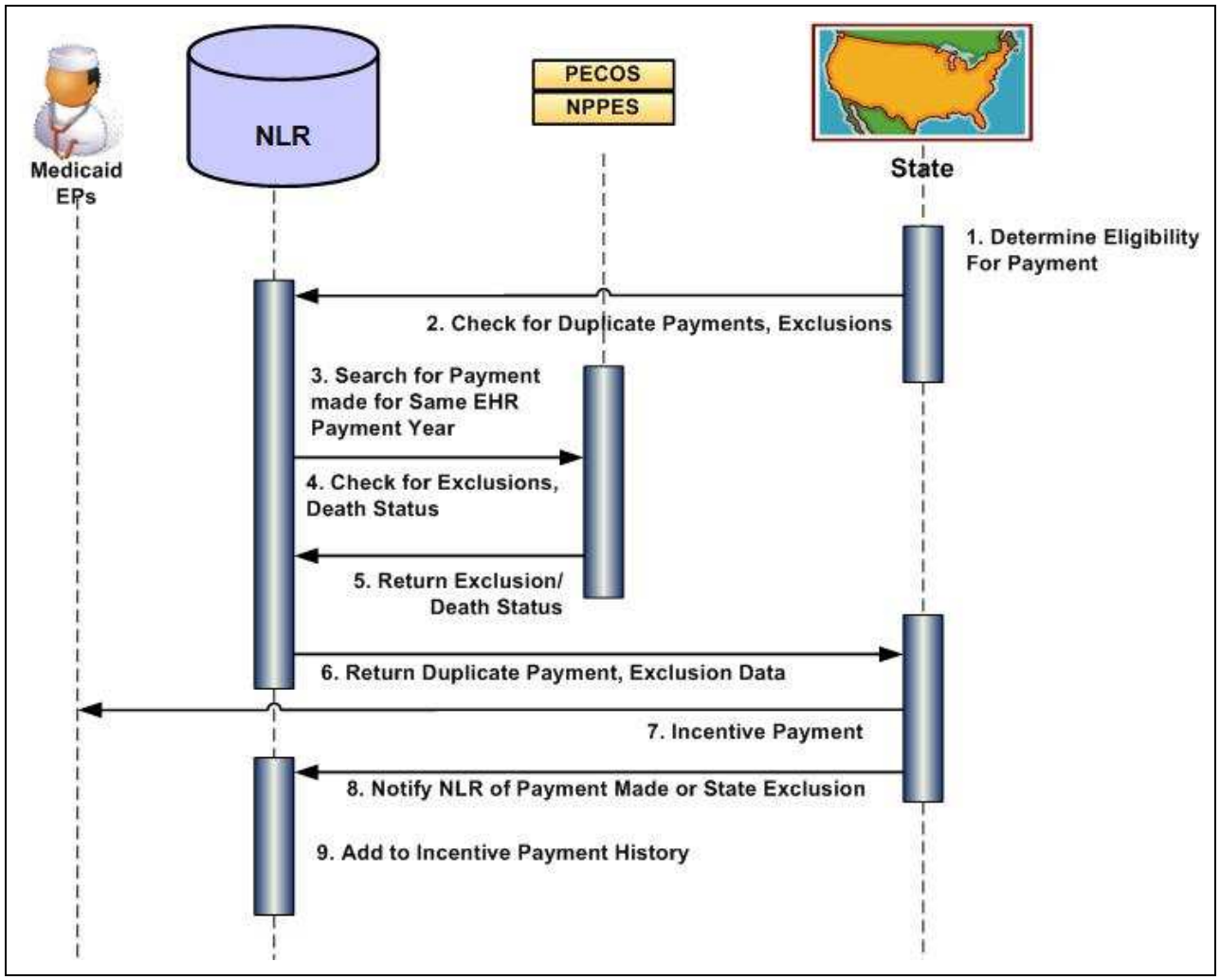

Figure 11: Scenario 6 - Medicaid EP Payments

States compute and make payments to Medicaid EPs. States will interface with the NLR twice. The first interface will check for duplicate payments. The second State-NLR interface will update the NLR with payments issued.

The following interfaces, described in the appendix, support Scenario 6:

- Interface D-16: State – NLR (with NLR response) to check for duplicate payments and exclusions
- Interface D-6: NLR – PECOS to determine death/exclusion status of Medicaid providers if the EP is also a Medicare provider
- Interface D-18: State – NLR to update the NLR with State incentive payment data

9.2.2 Scenario 7: Medicaid Hospital Payment

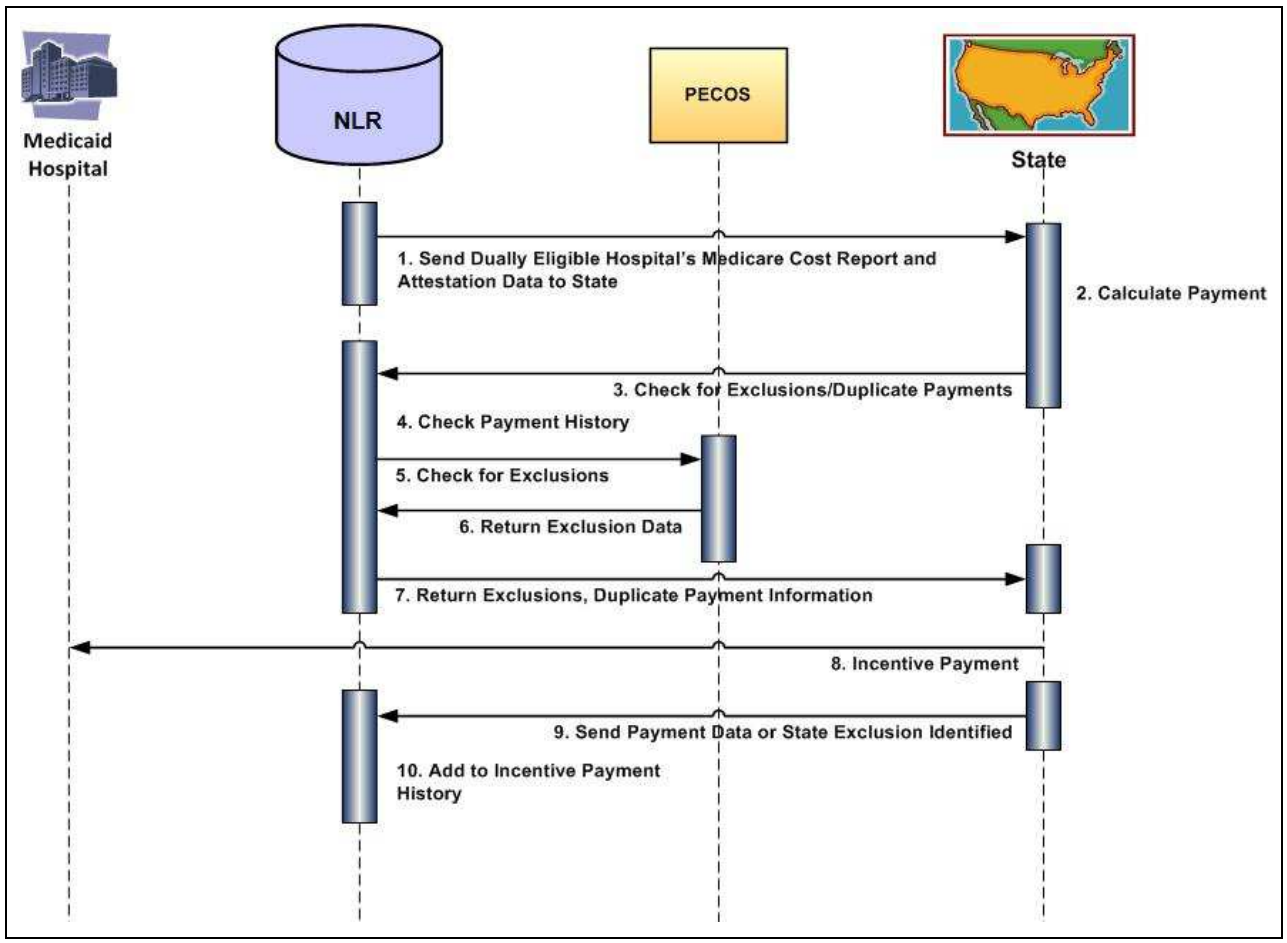

Figure 12: Scenario 7 - Medicaid Dually Eligible Hospital Payment

States compute and make payments to Medicaid hospitals. The NLR will send States relevant attestation data and the Medicare incentive payment calculation statistics. States will then interface with the NLR twice. The first interface will check for duplicate payments. The second State-NLR interface will update the NLR with payments issued.

The following interfaces, described in the appendix, support Scenario 7:

- Interface C-5: NLR – State to send attestation information that Dually Eligible hospitals submit to CMS via the Attestation Module
- Interface D-17: NLR – State, Dually Eligible Hospital Cost Report Data
- Interface D-16: State – NLR (with NLR response), Duplicate Payment/Exclusion Check
- Interface D-6: NLR – PECOS to determine death/exclusion status of Medicaid providers if the EP is also a Medicare provider
- Interface D-18: State – NLR, Incentive Payment Data

10 EXCEPTION HANDLING FOR INTERFACES

Section 11 describes the exception handling process for the interfaces. The following is the standard interface for communication of batch process errors. The error file will transmit data from the NLR or the interfacing system regarding file-level and record-level errors. If a file contains file-level errors, individual records will not be processed; therefore an error file will only contain information on file-level errors or transaction-level errors.

Field Name	Data Element	Description	Details
Batch Information			
BatchFileName	Batch File Name	Name of the batch file processed with errors	String(1-44)
FileControlNumber	File Control Number	Control number of the file processed with errors	String(1-10)
BatchRecordsCount	Batch Records Count	Total number of batch records contained in the file processed with errors	Integer MinValue: 0 MaxValue: 9999999
BatchRecordsProcessedCount	Batch Records Processed Count	Number of batch records successfully processed in the file containing errors; will be set to zero if file-level errors are encountered	Integer MinValue: 0 MaxValue: 9999999
Batch-Level Error Information			
BatchLevelErrors	Batch-Level Errors	List of the file-level errors (including error code, text description, and verbose error message) encountered in processing, multiple errors may be sent; will not be sent if transaction-level errors are being reported	BatchLevelErrorCode: String(2-10) BatchLevelErrorDesc: String(1-120) BatchLevelErrorMsg: String(1-500)

Field Name	Data Element	Description	Details
Transaction-Level Error Information			
ErrorTransaction Number	Error Transaction Number	Transaction Number of the record containing errors; no transaction-level errors will be sent if file-level errors are being reported	String(1-18)
TransactionLevel ErrorDetails	Transaction-Level Error Details	List of the errors (including error code, text description, and verbose error message) encountered in processing the specific transaction, multiple errors may be sent; no transaction-level errors will be sent if file-level errors are being reported	TransactionLevelError Code: String(2-10) TransactionLevelError Desc: String(1-120) TransactionLevelError Msg: String(1-500)

Additional details are included in the latest Batch Record Errors XSD, dated April 30, 2011.


BatchProcessErrors_ R3_0.xsd

Also attached is the Batch Record Errors XSD for Release 11.04, dated April 30, 2011. Please note there are no substantive changes between the Release 11.03 and 11.04 Batch Record Errors XSDs.


BatchProcessErrors_ R4_0.xsd

11 INTERFACES SUPPORTING REGISTRATION

11.1 Registration of Medicaid Eligible Professionals and Hospitals

11.1.1 Interface B-6: NLR – States, Provider Registration Data

Overview	
Purpose	To inform the States of new, updated and cancelled Medicaid registrations. The NLR will send the States batch feeds of new EPs and Hospitals that signed up for HITECH and selected, or switched to, Medicaid.
Frequency	Daily
Trigger	Production Schedule
Mode	Batch
Format	XML
Sending System	NLR [EDC]
Receiving System	States [Other]
Estimated Transaction Volume	
Estimated Transaction Size	

Data Elements from NLR to States

XML Tag	**Data Element**	**Description**	**Details**
Identifying Information			
NPI	NPI	National Provider Identifier where the source system is NPPES (National Plan and Provider Enumeration System)	String(10)

XML Tag	Data Element	Description	Details
TIN	Personal TIN	Personal Taxpayer Identification Number, also indicates if TIN is EIN or SSN	Value: String(9) Type: Enumeration
PayeeNPI	Payee NPI	National Provider Identifier of the entity receiving payment (may be same as NPI)	String(10)
PayeeTIN	Payee TIN	The Taxpayer Identification Number for the entity receiving payment, also indicates if TIN is EIN or SSN (may be same as TIN)	Value: String(9) Type: Enumeration
CCN	CCN	The CCN of the hospital receiving payment (applies only to hospitals)	String(6-10)
Control Information			
Confirmation Number	Registration ID	Unique number created by the NLR and used by the State, if desired, to confirm the provider's identity for registration	String(10)
TransactionNumber	Transaction Number	A unique identifier for each record on the interface data The format of the Transaction Number is: FileControlNumber + a dash + a 7-character sequence number	String(9-18)
TransactionType	Transaction Type	Indicates whether the data being sent to the State represents a new or updated registration or an inactivation	Enumeration

XML Tag	Data Element	Description	Details
TransactionDate	Transaction Date	The date that the Medicaid EP or Hospital utilized the Registration Module to add, update, or change the record	DateTime (YYYY-MM-DDTHH:MI:SS)
Additional Information			
ProgramOption	Program Option	Provider's choice of program to use for incentives (Medicare or Medicaid); Hospitals may select Dually Eligible	Enumeration
MedicaidState	Medicaid State	The selected State for Medicaid participation	String(2)
StateCode (in Header)	State ID	The State to whom the file is sent	String(2)
ProviderType	Provider Type	The provider type according to the HITECH legislation	Enumeration
PersonName	Person Name	Provider's name if the provider is an individual, not present otherwise	FirstName: String(1-25) MiddleName: String(25) LastName: String(1-35) Suffix: String(10)
LegalName	Legal Name	Legal name of business or organization	String(5-75)

XML Tag	Data Element	Description	Details
Address	Business Address	Address of the provider	AddressLine1: String(1-55) AddressLine2: String(55) CityName: String(1-30) State: String(2) Zip5: String(5) Zip4: String(4) PhoneNumber: String(15) PhoneExtension: String(15)
PaymentYear	EHR Payment Year	The year for the provider's participation in the HITECH program (as in Year 1, Year 2, etc.)	Integer MinValue: 1 MaxValue: 6
ProviderSpecialties	Provider Specialty (Primary Provider Taxonomy)	As provided in PECOS Organizational Taxonomy; Multiple values may be sent	String(150)
FederalExclusions	Federal Exclusions	List of any federal exclusions for the provider; Multiple exclusions may be sent	Code: String(4-10) Description: String(15-120) StartDate: Date (YYYY-MM-DD) EndDate: Date (YYYY-MM-DD)

XML Tag	Data Element	Description	Details
StateRejection Reasons	State Rejection Reasons	List of any state exclusions or other state rejection codes; Multiple reasons may be sent	Code: String(2-4) Description: String(4-120) State: String(2) Date: Date (YYYY-MM-DD)
ContactEmail	Contact E-Mail	E-Mail address of the provider contact	String(80)
EHRCertificationNumber	EHR Certification Number	CMS Certification Number, corresponding to a unique set of certified EHR products/modules, as entered by provider during registration	String(1-15)

Additional details are included in the detailed B-6 ICD, dated June 10, 2011. The detailed B-6 ICD was created as a standalone document and is included in this section as an attachment.

NGC_HITECH_NLR_B-6_Interface_ICD_Dr

11.1.2 Interface B-7: States – NLR, Registration Confirmation Data

Overview	
Purpose	To update the NLR regarding the final eligibility of EPs and Hospitals that selected Medicaid. States will send the NLR the eligibility for each of the new, changed, or updated registrations.
Frequency	Daily
Trigger	Production Schedule
Mode	Batch
Format	XML
Sending System	States [Other]
Receiving System	NLR [EDC]
Estimated Transaction Volume	
Estimated Transaction Size	

Data Elements from States to NLR

XML Tag	Data Element	Description	Details
Identifying Information			
NPI	NPI	National Provider Identifier where the source system is NPPES (National Plan and Provider Enumeration System)	String(10)
TIN	Personal TIN	Personal Taxpayer Identification Number, also indicates if TIN is EIN or SSN	Value: String(9) Type: Enumeration
PayeeNPI	Payee NPI	National Provider Identifier of the entity receiving payment (may be same as NPI)	String(10)

XML Tag	Data Element	Description	Details
PayeeTIN	Payee TIN	The Taxpayer Identification Number for the entity receiving payment, also indicates if TIN is EIN or SSN (may be same as TIN)	Value: String(9) Type: Enumeration
CCN	CCN	The CCN of the hospital receiving payment (applies only to hospitals)	String(6-10)
Control Information			
TransactionNumber	Transaction Number	Transaction number generated by the State for the confirmation record	String(1-18)
OriginalTransaction Number	Original Transaction Number	The transaction number provided on the latest B-6 record from the NLR	String(9-18)
ConfirmationNumber	Registration ID	Unique number created by the NLR and used by the State, if desired, to confirm the provider's identity for registration	String(10)
OriginalTransaction Type	Original Transaction Type	The transaction type provided on the latest B-6 record from the NLR; response for B-6 inactivation record is not anticipated	Enumeration
TransactionDate	Transaction Date	Date/time of the B-7 response file from the State	DateTime (YYYY-MM-DDTHH:MI:SS)
Additional Information			
StateCode (in Header)	State	The State sending the file	String (2)
StateRegistrationDate	State Registration Date	Date the registration transaction was completed with the State; only applies to eligible registrations	DateTime (YYYY-MM-DDTHH:MI:SS)

XML Tag	Data Element	Description	Details
EligibilityStatus	Eligibility Status	Provider's eligibility for registration as determined by the State	Enumeration
RejectionReasons	State Rejection Reasons	List of any state exclusions or other state rejection codes; multiple reasons may be sent	Code: String(2-4) Description: String(4-120)

Additional details are included in the detailed B-7 ICD, dated June 10, 2011. The B-7 ICD was created as a standalone document and is included in this section as an attachment.

NGC_HITECH_NLR_B-7_Interface_ICD_Dr

12 INTERFACES SUPPORTING ATTESTATION

12.1 Attestation of Medicaid Providers

12.1.1 Interface C-4: State – CHPL Web Service, EHR Certification Number Validation

Overview	
Purpose	To verify that an EHR Certification Number received from the NLR, or entered by the Medicaid provider, is valid.
Frequency	Occurs as an EHR Certification Number is received by the State
Trigger	Processing of B-6 file or entry by Medicaid provider in State system
Mode	Web Service
Format	XML
Sending System	Registration / Attestation Module [BDC]
Receiving System	ONC CHPL Web Service [Other]
Estimated Transaction Volume	
Estimated Transaction Size	

Data Elements for State to CHPL Web Service

Data Element	Description	Details
Identifying Information		
muid	EHR Certification Number	String

Data Elements for CHPL Web Service to State

Data Element	Description	Details
Identifying Information		

Data Element	Description	Details
muid	EHR Certification Number	String
Additional Information		
valid	Indicates if the referenced EHR Certification Number is valid	Boolean

12.2 Attestation of Dually Eligible Hospitals

12.2.1 Interface C-5: NLR – State, Dually Eligible Hospital Attestation Data

Overview	
Purpose	To send States attestation information submitted by Dually Eligible Hospitals via the CMS Attestation Module.
Frequency	Daily
Trigger	Production Schedule
Mode	Batch
Format	XML
Sending System	NLR [EDC]
Receiving System	State [Other]
Estimated Transaction Volume	
Estimated Transaction Size	

Data Elements for NLR to States

XML Tag	Data Element	Description	Details
Identifying Information			
NPI	NPI	National Provider Identifier where the source system is NPPES (National Plan and Provider Enumeration System)	String(10)
TIN	TIN	The Taxpayer Identification Number for the hospital	Type: Enumeration Value: String(9)
CCN	CCN	CMS Certification Number	String(6-10)

XML Tag	Data Element	Description	Details
Control Information			
ConfirmationNumber	Registration ID	Provider's Confirmation Number/Registration ID as assigned at registration	String(10)
AttestationID	Attestation ID	Unique identifier for the attestation record; does not change upon subsequent updates and re-submissions	String(10)
TransactionNumber	Transaction Number	A unique identifier for each record on the interface The format of the Transaction Number is: FileControlNumber + a dash + a 7 character sequence number	String(9-18)
TransactionDate	Transaction Date	Date of the transaction	DateTime (YYYY-MM-DDTHH:MI:SS)
Hospital Stage 1 EHR Meaningful Use and Clinical Quality Measure Data			
Attestation Information			
Attestation ConfirmationNumber	Attestation Confirmation Number	Confirmation number generated for the attestation record; unique confirmation number generated for each submission	String(10)
EHRCertification Number	EHR Certification Number	CMS Certification Number provided by the ONC, which is the number that corresponds to a unique set of certified EHR products/modules	String(15)
EHRVendor	EHR Vendor	Name of the EHR Vendor, if provided	String(25)
EHRVersion	EHR Version	Version of the EHR software, if provided	String(18)

XML Tag	Data Element	Description	Details
AttestationStatus	Attestation Status	Status of the attestation record; indicates if the record has been accepted, rejected, suspended, or cancelled	Enumeration
MedicareProgramYear	Medicare Program Year	Program Year (i.e. 2011, 2012, etc) corresponding to the attestation record	Integer
MedicarePaymentYear	Medicare EHR Payment Year	Medicare EHR Payment Year for the Hospital corresponding to the attestation record (i.e. Year 1, 2, etc)	Integer MinValue: 1 MaxValue: 6
SubmitDate	Submit Date	Date the attestation record was submitted	Date (YYYY-MM-DD)
EDAdmissionMethod Code	Emergency Department Admission Method Code	Indicates the Hospital's Emergency Department Admission Method	Enumeration
StageNumber	Stage Number	Indicates the Meaningful Use Stage corresponding to the attestation record.	Integer minValue: 1 maxValue: 3
EHRReportingPeriod	EHR Reporting Period	Reporting period corresponding to the attestation record	EHRReportStartDate: Date (YYYY-MM-DD) EHRReportEndDate: Date (YYYY-MM-DD)
AttestationCompliance	Attestation Compliance	Compliance determination corresponding to the attestation record	Determination: Enumeration Reason: String(250)

XML Tag	Data Element	Description	Details
Note: The following italicized field will be added to the schema as of Release 12.01.			
CQMElectionDecision	*CQM Election Decision*	*Indicates whether the provider has chosen to participate in the CQM eReporting Pilot Program; otherwise CQMs are manually entered*	*Enumeration*
Category Information			
CategoryDescription	Category Description	Description of the attestation category	Enumeration
CategoryCompletion Status	Category Completion Status	Completion status of the attestation category	Enumeration
CategoryCompliance	Category Compliance	Compliance determination for the attestation category	Determination: Enumeration Reason: String(250)
Objective Information			
ObjectiveNumber	Objective Number	Identification number corresponding to each attestation objective	String(30)
ObjectiveName	Objective Name	Name of the attestation objective	String(50)
ObjectiveCompliance	Objective Compliance	Compliance determination for the attestation objective	Determination: Enumeration Reason: String(250)
Measure Information			
MeasureDeferred Indicator	Measure Deferred Indicator	Indicates whether the hospital has deferred the attestation measure	Boolean
MeasureCompliance	Measure Compliance	Compliance determination for the attestation measure	Determination: Enumeration Reason: String(250)

XML Tag	Data Element	Description	Details
Sub-Measure Information			
CalculatedPercentage Number	Calculated Percentage Number	Calculated percentage for the attestation sub-measure	Decimal totalDigits: 5 fractionDigits: 2 minValue: 0.00 maxValue: 100.00
BooleanMeasureValue	Boolean Measure Value	Boolean value for measures with Boolean data type	Boolean
NumeratorDenominator Group	Numerator/ Denominator Group	Numerator/denominator combination for measures requiring numerator and denominator values	Numerator: Integer Denominator: Integer
SubMeasureCompliance	Sub-Measure Compliance	Compliance determination for the attestation sub-measure	Determination: Enumeration Reason: String(250)
Exclusion Information			
BooleanAttestation	Boolean Attestation	Indicates that the hospital has attested to the exclusion	Boolean
BooleanExclusion	Boolean Exclusion	If applicable, Boolean value for the exclusion	Boolean
IntegerExclusion	Integer Exclusion	If applicable, integer value for the exclusion	Integer
Cancellation Information			
CancellationNumber	Cancellation Number	Unique identification number corresponding to cancellation of the attestation record Only applies to cancelled attestation record	String(10)
CancellationDate	Cancellation Date	Date the attestation record was cancelled Only applies to cancelled attestation record	Date (YYYY-MM-DD)

XML Tag	Data Element	Description	Details
CancellationReason Text	Cancellation Reason	Reason for the cancellation of the attestation record Only applies to cancelled attestation record	String(1000)

Additional details are included in the detailed C-5 ICD, dated October 5, 2011. The C-5 ICD was created as a standalone document and is included in this section as an attachment. Please note the XSD contained in this document contains the change taking effect in Release 12.01 (January 2012).

NGC_HITECH_NLR_R 12.01_C-5_Interface

13 INTERFACES SUPPORTING PAYMENT

13.1 Payment to Medicaid Hospitals and Eligible Professionals

13.1.1 Interface D-16: State – NLR, Duplicate Payment/Exclusion Check

Overview	
Purpose	To prevent duplicate EHR incentive payments for providers between Medicare and Medicaid or between multiple Medicaid states.
Frequency	Limit of once per day per State
Trigger	Production Schedule
Mode	Batch
Format	XML
Sending System	State [Other]
Receiving System	NLR (with NLR response) [EDC]
Estimated Transaction Volume	
Estimated Transaction Size	

Note: Once a State has requested the duplicate payment/exclusion check for a provider, the provider will have a "Locked for Payment" status, which will be sent to any other State requesting the check to prevent duplicate payments.

Data Elements for State Request to NLR

XML Tag	**Data Element**	**Description**	**Details**
Identifying Information			
NPI	NPI	National Provider Identifier where the source system is NPPES (National Plan and Provider Enumeration System)	String(10)

XML Tag	Data Element	Description	Details
TIN	TIN	The Taxpayer Identification Number for the registered provider, also indicates if TIN is EIN or SSN	Value: String(9) Type: Enumeration
PayeeNPI	Payee NPI	National Provider Identifier of the entity receiving payment (may be same as NPI)	String(10)
PayeeTIN	Payee TIN	The Taxpayer Identification Number for the entity receiving payment, also indicates if TIN is EIN or SSN (may be same as TIN)	Value: String(9) Type: Enumeration
CCN	CCN	The CCN of the hospital receiving payment (applies only to hospitals)	String (6-10)
Control Information			
TransactionNumber	Transaction Number	A unique identifier for each record on the interface data	String(1-18)
ConfirmationNumber	Registration ID	Unique number created by the NLR and used by the State, if desired, to confirm the provider's identity for registration	String(10)
Additional Information			
IntendToPay Amount	Payment Amount	The incentive payment amount that the State has calculated for the provider	Decimal Total Digits: 15 Fraction Digits: 2
PaymentState	State	The State requesting information from the NLR	String(2)
PaymentType	Payment Type	Type of payment to be made (initial or adjustment)	Enumeration
PaymentYear	EHR Payment Year	The EHR Payment year to which the payment will apply	Integer MinValue: 1 MaxValue: 6

XML Tag	Data Element	Description	Details
Note: The following italicized field will be added to the schema as of Release 12.01.			
ProgramYear	*Program Year*	*The Program Year (i.e. 2011, 2012, etc) to which the payment will apply*	*Enumeration*

Data Elements for NLR Response to State

XML Tag	Data Element	Description	Details
Identifying Information			
NPI	NPI	National Provider Identifier where the source system is NPPES (National Plan and Provider Enumeration System)	String(10)
TIN	TIN	The Taxpayer Identification Number for the registered provider, also indicates if TIN is EIN or SSN	Value: String(9) Type: Enumeration
PayeeNPI	Payee NPI	National Provider Identifier of the entity receiving payment (may be same as NPI)	String(10)
PayeeTIN	Payee TIN	The Taxpayer Identification Number for the entity receiving payment, also indicates if TIN is EIN or SSN (may be same as TIN)	Value: String(9) Type: Enumeration
CCN	CCN	The CCN of the hospital receiving payment (applies only to hospitals)	String (6-10)
Control Information			
OriginalTransaction Number	Original Transaction Number	A return of the original Transaction Number sent on the D-16 Request from the State	String(1-18)

XML Tag	Data Element	Description	Details
ConfirmationNumber	Registration ID	Unique number created by the NLR and used by the State, if desired, to confirm the provider's identity for registration	String(10)
TransactionNumber	Transaction Number	Transaction number for the response record The format of the Transaction Number is: FileControlNumber + a dash + a 7-character sequence number	String(9-18)
Additional Information			
PaymentIndicator	Payment Indicator	Indicates if payment data exists for the requested provider: Y: The Provider has been paid N: The Provider has not been paid	Boolean
PaymentYear	EHR Payment Year	EHR Payment Year to which the payment applies	Integer MinValue: 1 MaxValue: 6
CumulativePayment Amount	Payment Amount	The cumulative incentive payment amount to the provider for the corresponding EHR Payment Year	Decimal Total Digits: 15 Fraction Digits: 2
PaymentState	State	The State that has issued payment, or has a pending payment for this provider	String(2)
PaymentProgram Option	Program Option	The program that paid the provider	Enumeration
PaymentDate	Payment Date	The date of the payment to the EP or hospital	Date (YYYY-MM-DD)

XML Tag	Data Element	Description	Details
FederalExclusions	Federal Exclusions	List of any federal exclusions for the provider, including start and end dates; Multiple exclusions may be sent	Code: String(4-10) Description: String(15-120) StartDate: Date (YYYY-MM-DD) EndDate: Date (YYYY-MM-DD)
StateRejection Reasons	State Rejection Reasons	List of any state exclusions or other state rejection codes; Multiple reasons may be sent	Code: String(2-4) Description: String(4-120) State: String(2) Date: Date (YYYY-MM-DD)
Note: The following italicized field will be added to the schema as of Release 12.01.			
ProgramYear	*Program Year*	*The Program Year (i.e. 2011, 2012, etc) to which the payment will apply*	*Enumeration*

Additional details are included in the detailed D-16 ICD, dated July 26, 2011. The D-16 ICD was created as a standalone document and is included in this section as an attachment. Please note the XSDs contained in the document do not contain the changes taking effect in Release 12.01 (January 2012).

NGC_HITECH_NLR_D-16_Interface_ICD_F

13.1.2 Interface D-17: NLR – State, Dually Eligible Hospital Cost Report Data

Overview	
Purpose	To send States the cost report data elements utilized by CMS to determine Medicare hospital payments for Dually Eligible hospitals deemed eligible for the Medicaid HITECH incentive payment. The state will receive the cost report after a Dually Eligible hospital successfully attests for Medicare and the cost information is retrieved from the Shared Systems. The Medicare cost report is for information only to the states as an aid to use in computing the Medicaid payments.
Frequency	Monthly
Trigger	Production Schedule
Mode	Batch
Format	
Sending System	NLR [EDC]
Receiving System	State [Other]
Estimated Transaction Volume	
Estimated Transaction Size	

Data Elements from NLR to State

XML Tag	Data Element	Description	Details
Identifying Information			
NPI	NPI	National Provider Identifier where the source system is NPPES (National Plan and Provider Enumeration System)	String(10)

XML Tag	Data Element	Description	Details
TIN	TIN	Taxpayer Identification Number that is to be used for payment	Type: Enumeration Value: String(9)
CCN	CCN	CMS Certification Number (for hospitals)	String(6-10)
Control Information			
ConfirmationNumber	Registration ID	Provider's Confirmation Number/Registration ID as assigned at registration	String(10)
TransactionNumber	Transaction Number	A unique identifier for each record on the interface data The format of the Transaction Number is: FileControlNumber + a dash + a 7-character sequence number	String(1-18)
Additional Information			
TypeOfReport	Data Status	Indicates if cost report is initial or adjustment	Enumeration
ProviderType	Provider Type	Indicates the type of Hospital	Enumeration
MedicarePaymentYear	Medicare EHR Payment Year	The year for the provider's participation in the Medicare HITECH program (as in Year 1, Year 2, etc.)	Integer MinValue: 1 MaxValue: 6
CostReportBeginDate	Cost Report Begin Date	Begin date for the cost report data	Date (YYYY-MM-DD)
CostReportEndDate	Cost Report End Date	End date for the cost report data	Date (YYYY-MM-DD)
AdjustedCostReport BeginDate	Adjusted Cost Report Begin Date	Begin date for adjusted cost report data	Date (YYYY-MM-DD)

XML Tag	Data Element	Description	Details
AdjustedCostReport EndDate	Adjusted Cost Report End Date	End date for adjusted cost report data	Date (YYYY-MM-DD)
For Subsection (d) and Critical Access Hospitals			
TotalDischarges	Total Discharges	The total discharges obtained from the hospital fiscal year that ends during the Federal fiscal year prior to the fiscal year that serves as the payment year; will be zero for a CAH provider	Integer MinValue: 0 MaxValue: 999999
InpatientPartADays	Inpatient Part A Days	The total inpatient Part A Days obtained from the hospital fiscal year that ends during the Federal fiscal year prior to the fiscal year that serves as the payment year; will be zero for a CAH provider	Integer MinValue: 0 MaxValue: 999999999
InpatientPartCDays	Inpatient Part C Days	The total inpatient Part C Days obtained from the hospital fiscal year that ends during the Federal fiscal year prior to the fiscal year that serves as the payment year; will be zero for a CAH provider	Integer MinValue: 0 MaxValue: 999999999
TotalInpatientDays	Total Inpatient Days	The sum of “Total Inpatient Part A Days” and “Total Inpatient Part C Days”; will be zero for a CAH provider	Integer MinValue: 0 MaxValue: 9999999999
CharityCareCharges	Charity Care Charges	The total hospital charity care charges for the year, obtained from the hospital fiscal year that ends during the Federal fiscal year prior to the fiscal year that serves as the payment year	Decimal Total Digits: 11 Fraction Digits: 2

XML Tag	Data Element	Description	Details
TransitionFactor	Transition Factor	Will be 1.00 if "Hospital MU Effective Date" is greater than 09302010 and less than 10012013; 0.75 if "Hospital MU Effective Date" is greater than 09302013 and less than 10012014; 0.50 if "Hospital MU Effective Date" is greater than 09302014 and less than 10012015; 0 if "Hospital MU Effective Date" is greater than 09302015	Decimal Total Digits: 3 Fraction Digits: 2
For Subsection (d) Hospitals			
MCARESharefor SubsecDHospital	Subsection D Medicare Share	If this is an acute hospital, the Medicare Share for the hospital's EHR payment year Medicare Share = (Part A Days + Part C days) ÷ [(Total Inpatient Days)(Hospital charges – Charity Care charges) ÷ Hospital Charges]	Decimal Total Digits: 5 Fraction Digits: 4
HospitalBaseAmount	Hospital Base Amount	The hospital base amount	Decimal Total Digits: 9 Fraction Digits: 2
HospitalCharges	Hospital Charges	The total hospital charges, obtained from the hospital fiscal year that ends during the Federal fiscal year prior to the fiscal year that serves as the payment year	Decimal Total Digits: 14 Fraction Digits: 2
DischargeBasedAmount	Discharge Based Amount	The product of $200 x "Total Discharges" This amount is applicable only for each 1,150th through 23,000th discharge; will be zeroes if "Total Discharges" is less than 1,150 The product cannot exceed $4,600,000	Decimal Total Digits: 9 Fraction Digits: 2

XML Tag	Data Element	Description	Details
For Critical Access Hospitals			
MCAREShareforCAH	CAH Medicare Share	The sum of the Medicare share (as specified under paragraph (2)(D) of section 1886(n)) and 20 percentage points	Decimal Total Digits: 5 Fraction Digits: 4
CAHReasonableCost	CAH Reasonable Cost	The reasonable cost for a CAH	Decimal Total Digits: 14 Fraction Digits: 2

Additional details are included in the detailed D-17 ICD, dated June 10, 2011. The D-17 ICD was created as a standalone document and is included in this section as an attachment.

NGC_HITECH_NLR_D
-17_Interface_ICD_D

13.1.3 Interface D-18: State – NLR, Incentive Payment Data

Overview	
Purpose	To update NLR records as soon as payment is made indicating successful incentive payments for Medicaid EPs and Medicaid and Dually Eligible hospitals.
Frequency	Daily -- The NLR will accept a D-18 file from the State on a daily basis; however, the timing of the D-18 transmission from the State should coincide with the State's payment cycle. The State does not need to send a D-18 if there are no payments to report, but should send a D-18 as soon as possible **after** payment has been made to a provider. The D-18 must not be sent prior the actual payment.
Trigger	Production Schedule
Mode	Batch
Format	XML
Sending System	State [Other]
Receiving System	NLR [EDC]
Estimated Transaction Volume	
Estimated Transaction Size	

Data Elements from State to NLR

XML Tag	Data Element	Description	Details
Identifying Information			
NPI	NPI	National Provider Identifier where the source system is NPPES (National Plan and Provider Enumeration System)	String(10)

XML Tag	Data Element	Description	Details
TIN	Personal TIN	Personal Taxpayer Identification Number, also indicates if TIN is EIN or SSN	Value: String (9) Type: Enumeration
PayeeNPI	Payee NPI	National Provider Identifier of the entity receiving payment (may be same as NPI)	String(10)
PayeeTIN	Payee TIN	The Taxpayer Identification Number for the entity receiving payment, also indicates if TIN is EIN or SSN (may be same as TIN)	Value: String(9) Type: Enumeration
CCN	CCN	The CCN of the hospital receiving payment (applies only to hospitals)	String (6-10)
Control Information			
TransactionNumber	Transaction Number	Unique number indentifying each transaction	String(1-18)
ConfirmationNumber	Registration ID	Unique number created by the NLR and used by the State, if desired, to confirm the provider's identity for registration	String(10)
Additional Information			
PaymentYear	EHR Payment Year	EHR Payment Year to which the payment applies (Year 1, Year 2, etc.)	Integer MinValue: 1 MaxValue: 6
PaymentAmount Disbursed	Payment Amount Disbursed	The incentive payment amount disbursed to the recipient	Decimal Total Digits: 15 Fraction Digits: 2

XML Tag	Data Element	Description	Details
PaymentAmount Calculated	Payment Amount Calculated	The calculated amount for the payment	Decimal Total Digits: 15 Fraction Digits: 2
MedicaidState	State	The State sending information from the NLR	String(2)
ProviderType	Provider Type	The provider type according to the HITECH legislation	Enumeration
PaymentDate	Payment Date	The date that payment was issued to the provider; PaymentDate **cannot** be a future date	Date
PaymentType	Payment Type	Type of payment made (initial or adjustment)	Enumeration
AdjustmentReasons	Reason Code	The reason for a payment adjustment; multiple reasons may be sent	Code: String(2-4) Description: String(4-120)
StateQualification	State Qualification	Indicates if the provider is qualified as MU or AIU	Enumeration
ProgramSelected	Program Option	Program selected for payment	Enumeration
PayeePersonName	Payee Person Name	Name of the payment recipient, if an individual	First Name: String(1-25) Middle Name: String(25) Last Name: String(1-35) Suffix: String(10)
PayeeOrganizationName	Payee Organization Name	Name of the payment recipient, if a business or organization	String(5-75)

XML Tag	Data Element	Description	Details
Note: The following italicized field will be removed from the schema as of Release 12.01.			
StateQualifiedDate	*State Qualified Date*	*The date that the EP or Hospital qualified with the State for EHR technology*	*Date*
Note: The following italicized field will be added to the schema as of Release 12.01.			
ProgramYear	*Program Year*	*The Program Year (i.e. 2011, 2012, etc) to which the payment applies*	*Enumeration*

Additional details are included in the detailed D-18 ICD, dated July 2, 2011. The D-18 ICD was created as a standalone document and is attached below. Please note the XSD contained in the document do not contain the changes taking effect in Release 12.01 (January 2012).

NGC_HITECH_NLR_D
-18_Interface_ICD_F

14 APPENDIX A: MEANINGFUL USE AND CLINICAL QUALITY MEASURES

The measures used for the 2011 and 2012 submissions for Electronic Health Record Incentives are presented below. These measures will be updated for the 2013-2014 submission. For 2011, the measures will be submitted by Attestation. If, for 2012, the CMS is ready, the submission will be by file transfer.

14.1 Medicare and Dually-Eligible Hospital Attestation

"The criteria for meaningful use are based on a series of specific objectives, each of which is tied to a measure that allows EPs and hospitals to demonstrate that they are meaningful users of certified EHR technology.

For Stage 1, which begins in 2011, there will be 25 objectives/measures for EPs and 24 objectives/measures for eligible hospitals. The objectives/measures have been divided into a core set and menu set. EPs and eligible hospitals must meet all objectives/measures in the core set (15 for EPs and 14 for eligible hospitals). They can choose to defer up to five remaining objectives/measures. Each objective/measure was evaluated for its potential applicability to all EPs and eligible hospitals. Where it is impossible for an EP or eligible hospital to meet a specific measure, an exclusion is defined in the final rule. If an exclusion applies to an EP or eligible hospital, then such professional or hospital does not have to meet that objective/measure in order to be determined a meaningful EHR user. For example, if an EP has two exceptions (one for a core objective/measure and one for a menu objective/measure), the EP would need to meet the remaining 14 objectives/measures in the core set and four of the remaining nine objectives/measures in the menu set.

In 2011, EPs, eligible hospitals and CAHs seeking to demonstrate Meaningful Use are required to submit aggregate clinical quality measure numerator, denominator, and exclusion data to CMS or the States by attestation. In 2012, EPs, eligible hospitals and CAHs seeking to demonstrate meaningful use must electronically submit clinical quality measures selected by CMS directly to CMS (or the States) through certified EHR technology. CMS recognizes that for clinical quality reporting to become routine, the administrative burden of reporting must be reduced. By using certified EHR technology to report information on clinical quality measures

electronically to a health information network, a State, CMS, or a registry, the burden on providers that are gathering the data and transmitting them will be greatly reduced."[1]

Medicare eligible hospitals and CAHs must also submit the ONC certification number of the EHR technology used. They attest by submitting the measures to the CMS Attestation Module for validation. The purpose of this scenario is to document the process of receiving and validating Stage 1 MU and CQM measures and attestations within the Attestation Module; notifying the hospital of the status and sending attestation measures information to the NLR for calculation of compliance and storage.

The Medicare eligible hospital and CAH may modify measures before attesting to their accuracy. Hospitals may also cancel an attestation after payment is issued and an automatic notice is sent to the MAC/overpayment contractor to initiate recovery of the overpayment.

[1] (CMS Office of Public Affairs) CMS FINALIZES DEFINITION OF MEANINGFUL USE OF CERTIFIED ELECTRONIC HEALTH RECORDS (EHR) TECHNOLOGY

14.1.1 Hospital Stage 1 Health IT Criteria Requiring Statistical Measure

14.1.1.1 Meaningful Use Core Objectives

Meaningful Use Number/ Objective Number	Stage 1 Eligible Hospital Meaningful Use Core Objectives	Measures	Method of Measure	Logic
MUCH0001/ EHCMU 01	Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.	More than 30% of all unique patients with at least one medication in their medication list admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one medication order entered using CPOE. PATIENT RECORDS: To meet an objective and its associated measure an eligible hospital or CAH shall extract data for all patients' records unless the eligible hospital or CAH is expressly permitted to extract data from patient records maintained using EHR technology.	Numerator and Denominator	N = a positive whole number where N≤D D= a positive whole number where D≥N
MUCH0002/ EHCMU 02	Implement drug-drug and drug-allergy interaction checks.	The eligible hospital or CAH has enabled this functionality for the entire EHR reporting period.	Yes/No	Checkbox to indicate either yes or no
MUCH0003/ EHCMU 03	Maintain an up-to-date problem list of current and active diagnoses.	More than 80 percent of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry or an indication that no problems are known for the patient recorded as structured data.	Numerator and Denominator	N = a positive whole number where N≤D D= a positive whole number where D≥N

Meaningful Use Number/ Objective Number	Stage 1 Eligible Hospital Meaningful Use Core Objectives	Measures	Method of Measure	Logic
MUCH0004/ EHCMU 04	Maintain active medication list.	More than 80 percent of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.	Numerator and Denominator	N = a positive whole number where N≤D D= a positive whole number where D≥N
MUCH0005/ EHCMU 05	Maintain active medication allergy list.	More than 80 percent of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.	Numerator and Denominator	N = a positive whole number where N≤D D= a positive whole number where D≥N
MUCH0006/ EHCMU 06	Record all of the following demographics; preferred language gender race ethnicity date of birth and preliminary cause of death in the event of mortality in the hospital or CAH.	More than 50% of all unique patients seen by the eligible hospital or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have demographics recorded as structured data.	Numerator and Denominator	N = a positive whole number where N≤D D= a positive whole number where D≥N

Meaningful Use Number/ Objective Number	Stage 1 Eligible Hospital Meaningful Use Core Objectives	Measures	Method of Measure	Logic
MUCH0007/ EHCMU 07	Record and chart changes in vital signs: height weight blood pressure Calculate and display body mass index (BMI) Plot and display growth charts for children 2-20 years, including BMI.	For more than 50% of all unique patients age 2 and over admitted to eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23), height, weight and blood pressure are recorded as structure data. PATIENT RECORDS: To meet an objective and its associated measure an eligible hospital or CAH shall extract data for all patients' records unless the eligible hospital or CAH is expressly permitted to extract data from patient records maintained using EHR technology.	Numerator and Denominator	N = a positive whole number where N≤D D= a positive whole number where D≥N
MUCH0008/ EHCMU 08	Record smoking status for patients 13 years old or older	More than 50 percent of all unique patients 13 years old or older admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have smoking status recorded as structured data.	Numerator and Denominator	N = a positive whole number where N≤D D= a positive whole number where D≥N

Meaningful Use Number/ Objective Number	Stage 1 Eligible Hospital Meaningful Use Core Objectives	Measures	Method of Measure	Logic
MUCH0008/ EHCMU 08 Exclusion	Record smoking status for patients 13 years old or older	EXCLUSION: Any eligible hospital or CAH that admits no patients 13 years or older to their inpatient or emergency department (POS 21 or 23). ATTEST: No Patients 13 years or older were admitted to the inpatient or emergency department during the EHR reporting period.	Yes/No	If "Yes", MUCH0008 must have N = 0, D = 0 If the exclusion is indicated "Yes", the hospital or CAH must attest.
MUCH0009/ EHCMU 09	Report hospital clinical quality measures to CMS or, in the case of Medicaid eligible hospitals, the States.	For 2011, provide aggregate numerator and denominator through attestation as discussed in section II(A)(3) of the proposed rule. For 2012, electronically submit the measures as discussed in section II (A) (3) of the proposed rule. PATIENT RECORDS: To meet an objective and its associated measure an eligible hospital or CAH shall extract data for all patients' records unless the eligible hospital or CAH is expressly permitted to extract data from patient records maintained using EHR technology.	Unique according to Measure	See CQM Edit Logic

Meaningful Use Number/ Objective Number	Stage 1 Eligible Hospital Meaningful Use Core Objectives	Measures	Method of Measure	Logic
MUCH0010/ EHCMU 10	Implement one clinical decision support rule related to a high priority hospital condition along with the ability to track compliance with that rule.	Implement one clinical decision support rule.	Yes/No	Checkbox to indicate either yes or no
MUCH0011/ EHCMU 11	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies, discharge summary, procedures), upon request.	More than 50 percent of all patients of the inpatient or emergency department of the eligible hospital or CAH (POS 21 or 23) who request an electronic copy of their health information are provided it within 3 business days. PATIENT RECORDS: To meet an objective and its associated measure an eligible hospital or CAH shall extract data for all patients' records unless the eligible hospital or CAH is expressly permitted to extract data from patient records maintained using EHR technology.	Numerator and Denominator	N = a positive whole number where N≤D D= a positive whole number where D≥N

Meaningful Use Number/ Objective Number	Stage 1 Eligible Hospital Meaningful Use Core Objectives	Measures	Method of Measure	Logic
MUCH0011/ EHCMU 11 Exclusion	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies, discharge summary, procedures), upon request.	EXCLUSION: Any eligible hospital or CAH that has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period. ATTEST: No requests from patients or their agents were received for an electronic copy of patient health information during the EHR reporting period.	Yes/No	If "Yes", MUCH0011 must have N = 0, D = 0 If the exclusion is indicated "Yes", the hospital or CAH must attest.
MUCH0012/ EHCMU 12	Provide patients with an electronic copy of their discharge instructions at time of discharge, upon request.	More than 50 percent of all patients who are discharged from an eligible hospital or CAH's inpatient department or emergency department (POS 21 or 23) and who request an electronic copy of their discharge instructions are provided it. PATIENT RECORDS: To meet an objective and its associated measure an eligible hospital or CAH shall extract data for all patients' records unless the eligible hospital or CAH is expressly permitted to extract data from patient records maintained using EHR technology.	Numerator and Denominator	N = a positive whole number where N≤D D= a positive whole number where D≥N

Meaningful Use Number/ Objective Number	Stage 1 Eligible Hospital Meaningful Use Core Objectives	Measures	Method of Measure	Logic
MUCH0012/ EHCMU 12 Exclusion	Provide patients with an electronic copy of their discharge instructions at time of discharge, upon request.	EXCLUSION: Any eligible hospital or CAH that has no requests from patients or their agents for an electronic copy of the discharge instructions during the EHR reporting period. ATTEST: No requests from patients or their agents were received for an electronic copy of the discharge instructions during the EHR reporting period.	Yes/No	If "Yes", MUCH0012 must have N = 0, D = 0 If the exclusion is indicated "Yes", the hospital or CAH must attest.
MUCH0013/ EHCMU 13	Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, diagnostic test results), among providers of care and patient authorized entities electronically.	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information	Yes/No	Checkbox to indicate either yes or no
MUCH0014/ EHCMU 14	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis per 45 CFR 164.308 (a) (1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.	Yes/No	Checkbox to indicate either yes or no

14.1.1.2 Meaningful Use Menu Objectives

Meaningful Use Number/ Objective Number	Eligible Hospital Meaningful Use Menu Objectives	Measures	Measurement	Logic
MUMH0015/ EHMMU 01	Implemented drug-formulary checks.	The eligible hospital or CAH has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period.	Yes/No or Defer	Checkbox to indicate one of the following: yes no defer
MUMH0016/ EHMMU 02	Record advance directives for patients 65 years old or older.	More than 50 percent of all unique patients 65 years old or older admitted to the eligible hospital's or CAH's inpatient department (POS 21) have an indication of an advance directive status recorded as structured data. PATIENT RECORDS: To meet an objective and its associated measure an eligible hospital or CAH shall extract data for all patients' records unless the eligible hospital or CAH is expressly permitted to extract data from patient records maintained using EHR technology.	Numerator and Denominator or Defer	N = a positive whole number where N≤D D= a positive whole number where D≥N Deferral checkbox If defer, N=0 and D=0.

Meaningful Use Number/ Objective Number	Eligible Hospital Meaningful Use Menu Objectives	Measures	Measurement	Logic
MUMH0016/ EHMMU 02 Exclusion	Record advance directives for patients 65 years old or older.	EXCLUSION: An eligible hospital or CAH that admits no patients age 65 years old or older during the EHR reporting period. ATTEST: No patients were admitted age 65 years old or older during the EHR reporting period.	Yes/No	If "Yes", EH_MU_CORE_AdvanceDirectives65 must have N = 0, D = 0 If the exclusion is indicated "Yes", the hospital or CAH must attest.

Meaningful Use Number/ Objective Number	Eligible Hospital Meaningful Use Menu Objectives	Measures	Measurement	Logic
MUMH0017/ EHMMU 03	Incorporate clinical lab-test results into EHR as structured data.	More than 40 percent of all clinical lab tests results ordered by an authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data. PATIENT RECORDS: To meet an objective and its associated measure an eligible hospital or CAH shall extract data for all patients' records unless the eligible hospital or CAH is expressly permitted to extract data from patient records maintained using EHR technology.	Numerator and Denominator or Defer	N = a positive whole number where N≤D D= a positive whole number where D≥N Deferral checkbox If defer, N=0 and D=0.
MUMH0018/ EHMMU 04	Generate lists of patients by specific conditions to use for quality improvements, reduction of disparities, or outreach.	Generate at least one report listing patients of the eligible hospital or CAH with a specific condition. PATIENT RECORDS: To meet an objective and its associated measure an eligible hospital or CAH shall extract data for all patients' records unless the eligible hospital or CAH is expressly permitted to extract data from patient records maintained using EHR technology.	Yes/ No or Defer	Checkbox to indicate one of the following: yes no defer

Meaningful Use Number/ Objective Number	Eligible Hospital Meaningful Use Menu Objectives	Measures	Measurement	Logic
MUMH0019/ EHMMU 05	Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.	More than 10 percent of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are provided patient-specific education resources	Numerator and Denominator or Defer	N = a positive whole number where N≤D D= a positive whole number where D≥N Deferral checkbox If defer, N=0 and D=0.
MUMH0020/ EHMMU 06	The eligible hospital or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.	The eligible hospital or CAH performs medication reconciliation for more than 50 percent of transitions of care in which the patient is admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23). PATIENT RECORDS: To meet an objective and its associated measure an eligible hospital or CAH shall extract data for all patients' records unless the eligible hospital or CAH is expressly permitted to extract data from patient records maintained using EHR technology.	Numerator and Denominator or Defer	N = a positive whole number where N≤D D= a positive whole number where D≥N Deferral checkbox If defer, N=0 and D=0.

Meaningful Use Number/ Objective Number	Eligible Hospital Meaningful Use Menu Objectives	Measures	Measurement	Logic
MUMH0021/ EHMMU 07	The eligible hospital or CAH that transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary of care record for each transition of care or referral.	The eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals. PATIENT RECORDS: To meet an objective and its associated measure an eligible hospital or CAH shall extract data for all patients' records unless the eligible hospital or CAH is expressly permitted to extract data from patient records maintained using EHR technology.	Numerator and Denominator or Defer	N = a positive whole number where N≤D D= a positive whole number where D≥N Deferral checkbox If defer, N=0 and D=0.
MUMH0022/ EHMMU 08	Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice.	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the eligible hospital or CAH submits such information has the capacity to receive the information electronically).	Yes/No or Defer	Checkbox to indicate one of the following: yes no defer

Meaningful Use Number/ Objective Number	Eligible Hospital Meaningful Use Menu Objectives	Measures	Measurement	Logic
MUMH0022/ EHMMU 08 Exclusion 1	Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice.	EXCLUSION: An eligible hospital or CAH that administers no immunizations during the EHR reporting period ATTEST: No immunizations were administered during the EHR reporting period.	Yes/No	If the hospital/CAH administered NO immunizations during the EHR reporting period, the first exclusion is checked and an attestation statement is displayed.

Meaningful Use Number/ Objective Number	Eligible Hospital Meaningful Use Menu Objectives	Measures	Measurement	Logic
MUMH0022/ EHMMU 08 Exclusion 2	Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice.	EXCLUSION: An eligible hospital or CAH where no immunization registry has the capacity to receive the information electronically. ATTEST: No immunization registry has the capacity to receive the information electronically.	Yes/No	The second exclusion does not have to be checked. If the hospital/CAH administered immunizations, and the registry is unable to receive the data electronically, the second exclusion is checked and the second attestation statement is displayed.

Meaningful Use Number/ Objective Number	Eligible Hospital Meaningful Use Menu Objectives	Measures	Measurement	Logic
MUMH0023/ EHMMU 09	Capability to submit electronic data on reportable (as required by State or local law) lab results to public health agencies and actual submission in accordance with applicable law and practice.	Performed at least one test of certified EHR technology capacity to provide electronic submission of reportable lab results to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which eligible hospital or CAH submits such information have the capacity to receive the information electronically).	Yes/No or Defer	Checkbox to indicate one of the following: yes no defer
MUMH0023/ EHMMU 09 Exclusion	Capability to submit electronic data on reportable (as required by State or local law) lab results to public health agencies and actual submission in accordance with applicable law and practice.	EXCLUSION: No public health agency to which the eligible hospital or CAH submits such information has the capacity to receive the information electronically. ATTEST: None of the public health agencies to which the eligible hospital or CAH submits such information has the capacity to receive the information electronically.	Yes/No	If the exclusion is indicated "Yes", the hospital or CAH must attest.

Meaningful Use Number/ Objective Number	Eligible Hospital Meaningful Use Menu Objectives	Measures	Measurement	Logic
MUMH0024/ EHMMU 10	Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice.	Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an eligible hospital or CAH submits such information have the capacity to receive the information electronically).	Yes/No or Defer	Checkbox to indicate one of the following: yes no defer
MUMH0024/ EHMMU 10 Exclusion	Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice.	EXCLUSION: No public health agency to which the eligible hospital or CAH submits information has the capacity to receive the information electronically. ATTEST: NONE of the public health agencies to which an eligible hospital or CAH submits such information have the capacity to receive the information electronically.	Yes/No	If the exclusion is indicated "Yes", the hospital or CAH must attest.

14.1.2 Hospital Clinical Quality Measures

CQM Name/Objective Number	Hospital Clinical Quality Measures	Measurement
ED-1.1, NQF 0495/NQF 495	Emergency Department Throughput – admitted patient's Median time (in minutes) from ED arrival to ED departure for patients admitted to the facility.	Numerator and Denominator
ED-1.1, NQF 0495/NQF 495 Exclusions	Emergency Department Throughput – admitted patient's Median time (in minutes) from ED arrival to ED departure for patients admitted to the facility. EXCLUSIONS: Observation & Mental Health Patients	Numeric
ED-1.2, NQF 0495/NQF 495	ED Observation patients- median time (in minutes) from ED arrival to ED departure for patients admitted to the facility from the ED.	Numerator and Denominator
ED-1.3, NQF 0495/NQF 495	ED patients with a principal Dx of Psychiatric or mental health disorder- median time (in minutes) from ED arrival to ED departure for patients admitted to the facility from the ED.	Numerator and Denominator
ED-2.1, NQF 0497/NQF 497	Emergency Department Throughput - admitted patients Admission decision time to ED departure time for admitted patients	Numerator and Denominator
ED-2.1, NQF 0497/NQF 497 Exclusions	Emergency Department Throughput - admitted patients Admission decision time to ED departure time for admitted patients EXCLUSIONS: Observation & Mental Health Patients	Numeric
ED-2.2, NQF 0497/NQF 497	Observation patients -median time (in minutes) from admit decision time to time of departure from the ED for patients admitted to inpatient status.	Numerator and Denominator
ED-2.3, NQF 0497/NQF 497	ED patients with a principal Dx of Psychiatric or mental health disorder - median time (in minutes) from admit decision time to time of departure from ED for patients admitted to inpatient status.	Numerator and Denominator

CQM Name/Objective Number	Hospital Clinical Quality Measures	Measurement
Stroke 2, NQF 0435/NQF 435	Ischemic stroke – Discharge on anti-thrombotics	Numerator and Denominator
Stroke 2, NQF 0435/NQF 435 Exclusions	Ischemic stroke – Discharge on anti-thrombotics EXCLUSIONS	Numeric
Stroke 3, NQF 0436/NQF 436	Ischemic stroke – Anticoagulation for A-fib/flutter	Numerator and Denominator
Stroke 3, NQF 0436/NQF 436 Exclusions	Ischemic stroke – Anticoagulation for A-fib/flutter EXCLUSIONS	Numeric
Stroke 4, NQF 0437/NQF 437	Ischemic stroke – Thrombolytic therapy for patients arriving within 2 hours of symptom onset	Numerator and Denominator
Stroke 4, NQF 0437/NQF 437 Exclusions	Ischemic stroke – Thrombolytic therapy for patients arriving within 2 hours of symptom onset EXCLUSIONS	Numeric
Stroke 5, NQF 0438/NQF 438	Ischemic or hemorrhagic stroke – Antithrombotic therapy by day 2	Numerator and Denominator
Stroke 5, NQF 0438/NQF 438 Exclusions	Ischemic or hemorrhagic stroke – Antithrombotic therapy by day 2 EXCLUSIONS	Numeric
Stroke 6, NQF 0439/NQF 439	Ischemic stroke –Discharge on statins	Numerator and Denominator

CQM Name/Objective Number	Hospital Clinical Quality Measures	Measurement
Stroke 6, NQF 0439/NQF 439 Exclusions	Ischemic stroke ‑Discharge on statins EXCLUSIONS	Numeric
Stroke 8, NQF 0440/NQF 440	Ischemic or hemorrhagic stroke ‑Stroke Education	Numerator and Denominator
Stroke 8, NQF 0440/NQF 440 Exclusions	Ischemic or hemorrhagic stroke ‑Stroke Education EXCLUSIONS	Numeric
Stroke 10, NQF 0441/NQF 441	Ischemic or hemorrhagic stroke ‑ Rehabilitation assessment	Numerator and Denominator
Stroke 10, NQF 0441/NQF 441 Exclusions	Ischemic or hemorrhagic stroke ‑ Rehabilitation assessment EXCLUSIONS	Numeric
VTE ‑ 1, NQF 0371/NQF 371	VTE prophylaxis within 24 hours of arrival	Numerator and Denominator
VTE ‑ 1, NQF 0371/NQF 371 Exclusions	VTE prophylaxis within 24 hours of arrival EXCLUSIONS	Numeric
VTE ‑ 2, NQF 0372/NQF 372	Intensive Care Unit VTE prophylaxis	Numerator and Denominator
VTE ‑ 2, NQF 0372/NQF 372 Exclusions	Intensive Care Unit VTE prophylaxis EXCLUSIONS	Numeric

CQM Name/Objective Number	Hospital Clinical Quality Measures	Measurement
VTE – 3, NQF 0373/NQF 373	Anticoagulation overlap therapy	Numerator and Denominator
VTE – 3, NQF 0373/NQF 373 Exclusions	Anticoagulation overlap therapy EXCLUSIONS	Numeric
VTE – 4, NQF 0374/NQF 374	Platelet monitoring on unfractionated heparin	Numerator and Denominator
VTE – 4, NQF 0374/NQF 374 Exclusions	Platelet monitoring on unfractionated heparin EXCLUSIONS	Numeric
VTE – 5, NQF 0375/NQF 375	VTE discharge instructions	Numerator and Denominator
VTE – 5, NQF 0375/NQF 375 Exclusions	VTE discharge instructions EXCLUSIONS	Numeric
VTE – 6, NQF 0376/NQF 376	Incidence of potentially preventable VTE	Numerator and Denominator
VTE – 6, NQF 0376/NQF 376 Exclusions	Incidence of potentially preventable VTE EXCLUSIONS	Numeric

14.2 Medicare EP Attestation

A Medicare EP shall submit attestation data to support meaningful use of EHR certified technology according to Stage 1 criteria.

Medicare EPs must meet all objectives and associated measures of the Stage 1 criteria specified as core objectives and five objectives of the Medicare EP's choice specified as menu objectives to meet the definition of a meaningful EHR user. A Medicare EP may exclude a particular Core or Menu objective if the objective allows that option and the Medicare EP meets the conditions of the exclusion and attests to meeting the conditions.

One of the five menu objectives and supporting measures selected by a Medicare EP must be either 1) the capability to submit electronic data to immunization registries or 2) capability to submit electronic syndromic surveillance unless an exclusion applies for each. When an exclusion exists, the required number of objectives and associated measures is reduced by a Medicare EP's exclusions.

For CQMs, a Medicare EP submits 3 core measures. If the 3 core CQMs have a denominator greater than zero, the Medicare EP must submit 3 additional CQMs from a list of 38. However, if one or more of the 3 core have a denominator of zero, then the alternate core measures must be submitted. In this case, an alternate measure must be reported for each zero denominator value for the core group. If none of the alternate core measures would have a denominator value, they all must be reported with zeros. Three additional measures must be submitted from the group of 38. The Medicare EP must attest to the accuracy of all measures submitted.

14.2.1 Medicare EP Stage 1 Health IT Criteria Requiring a Statistical Measure

14.2.1.1 Meaningful Use Core Objectives

Meaningful Use Number/ Objective Number	Stage 1 EP Meaningful Use CORE Objectives	Measures	Method of Measure	Logic
MUCP0025	Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines	More than 30% of all unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE. PATIENT RECORDS: To meet an objective and its associated measure an EP shall extract data for all patients' records unless the EP is expressly permitted to extract data from patient records maintained using EHR technology.	Numerator and Denominator	N = a positive whole number where N≤D D= a positive whole number where D≥N

Meaningful Use Number/ Objective Number	Stage 1 EP Meaningful Use CORE Objectives	Measures	Method of Measure	Logic
MUCP0025 Exclusion	Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines	EXCLUSION: Any EP who writes fewer than 100 prescriptions during the EHR reporting period. ATTEST: Fewer than 100 prescriptions were written during the EHR reporting period.	Yes/No	If "Yes", then MUCP0025 must have N=≤D; D= <100 If the exclusion is indicated "Yes", the EP must attest.
MUCP0026	Implement drug-drug and drug-allergy interaction checks	The EP has enabled this functionality for the entire EHR reporting period.	Yes/No	Checkbox to indicate one of the following: yes no
MUCP0027	Maintain an up-to-date problem list of current and active diagnoses.	More than 80 percent of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data.	Numerator and Denominator	N = a positive whole number where N≤D D= a positive whole number where D≥N

Meaningful Use Number/ Objective Number	Stage 1 EP Meaningful Use CORE Objectives	Measures	Method of Measure	Logic
MUCP0028	Generate and transmit permissible prescriptions electronically (eRx).	More than 40 percent of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology. PATIENT RECORDS: To meet an objective and its associated measure an EP shall extract data for all patients' records unless the EP is expressly permitted to extract data from patient records maintained using EHR technology.	Numerator and Denominator	N = a positive whole number where N≤D D= a positive whole number where D≥N Checkbox to indicate yes to the exclusion.
MUCP0028 Exclusion	Generate and transmit permissible prescriptions electronically (eRx).	EXCLUSION: Any EP who writes fewer than 100 prescriptions during the EHR reporting period. ATTEST: Fewer than 100 prescriptions were written during the EHR reporting period.	Yes/No	If “Yes”, then MUCP0028 must have N=≤D; D= <100 If the exclusion is indicated “Yes”, the EP must attest.

Meaningful Use Number/ Objective Number	Stage 1 EP Meaningful Use CORE Objectives	Measures	Method of Measure	Logic
MUCP0029	Maintain active medication list.	More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.	Numerator and Denominator	N = a positive whole number where N≤D D= a positive whole number where D≥N
MUCP0030	Maintain active medication allergy list.	More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.	Numerator and Denominator	N = a positive whole number where N≤D D= a positive whole number where D≥N
MUCP0031	Record all of the following demographics: Preferred language Gender Race Ethnicity Date of birth	More than 50% of all unique patients seen by the EP have demographics recorded as structured data.	Numerator and Denominator	N = a positive whole number where N≤D D= a positive whole number where D≥N

Meaningful Use Number/ Objective Number	Stage 1 EP Meaningful Use CORE Objectives	Measures	Method of Measure	Logic
MUCP0032	Record and chart changes in vital signs: Height Weight Blood pressure Calculate and display body mass index (BMI). Plot and display growth charts for children 2-20 years, including BMI.	More than 50% of all unique patients age 2 and over seen by the EP, height, weight and blood pressure are recorded as structure data. PATIENT RECORDS: To meet an objective and its associated measure an EP shall extract data for all patients' records unless the EP is expressly permitted to extract data from patient records maintained using EHR technology.	Numerator and Denominator	N = a positive whole number where N≤D D= a positive whole number where D≥N

Meaningful Use Number/ Objective Number	Stage 1 EP Meaningful Use CORE Objectives	Measures	Method of Measure	Logic
MUCP0032 Exclusion 1	Record and chart changes in vital signs: Height Weight Blood pressure Calculate and display body mass index (BMI). Plot and display growth charts for children 2-20 years, including BMI.	EXCLUSION Any EP who either sees no patients 2 years or older. ATTEST: NONE of the patients are 2 years or older	Yes/No	If "Yes", then MUCP0032 must have N=0; D= 0 If an EP selects yes for the age exclusion, the EP must attest to the age exclusion. There is no need to display 2nd exclusion.

Meaningful Use Number/ Objective Number	Stage 1 EP Meaningful Use CORE Objectives	Measures	Method of Measure	Logic
MUCP0032 Exclusion 2	Record and chart changes in vital signs: Height Weight Blood pressure Calculate and display body mass index (BMI). Plot and display growth charts for children 2-20 years, including BMI.	EXCLUSION: 1) Any EP who believes that ALL three vital signs of height, weight, and blood pressure of their patients have no relevance to their scope of practice. ATTEST: ALL three vital signs of height, weight, and blood pressure of their patients have no relevance to their scope of practice.	Yes/No	If "Yes", then MUCP0032 must have N=0; D= 0 If an EP selects NO for MUCP0032 Exclusion 1, display second exclusion for the EP to indicate Yes and attest that the objective is not relevant to the medical practice.

Meaningful Use Number/ Objective Number	Stage 1 EP Meaningful Use CORE Objectives	Measures	Method of Measure	Logic
MUCP0033	Record smoking status for patients 13 years old or older.	More than 50 percent of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data. PATIENT RECORDS: To meet an objective and its associated measure an EP shall extract data for all patients' records unless the EP is expressly permitted to extract data from patient records maintained using EHR technology.	Numerator and Denominator	N = a positive whole number where N≤D D= a positive whole number where D≥N
MUCP0033 Exclusion	Record smoking status for patients 13 years old or older.	EXCLUSION: Any EP who sees no patients 13 years or older. ATTEST: No patients were seen age 13 years or older.	Yes/No	If “Yes”, then MUCP0033 must have N = 0; D = 0 If the exclusion is indicated “Yes”, the EP must attest.

Meaningful Use Number/ Objective Number	Stage 1 EP Meaningful Use CORE Objectives	Measures	Method of Measure	Logic
MUCP0034	Report ambulatory clinical quality measures to CMS or in the case of Medicaid EPs, the States.	For 2011, provide aggregate numerator and denominator through attestation as discussed in section II(A)(3) of the final rule For 2012, electronically submit the measures as discussed in section II (A) (3) of the final rule. PATIENT RECORDS: To meet an objective and its associated measure an EP shall extract data for all patients' records unless the EP is expressly permitted to extract data from patient records maintained using EHR technology.	Unique according to measure	See CQM Edit Logic
MUCP0035	Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule.	Implement one clinical decision support rule.	Yes/No	Checkbox to indicate one of the following: yes no

Meaningful Use Number/ Objective Number	Stage 1 EP Meaningful Use CORE Objectives	Measures	Method of Measure	Logic
MUCP0036	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies), upon request.	More than 50 percent of all patients who request an electronic copy of their health information are provided it within 3 business days. PATIENT RECORDS: To meet an objective and its associated measure an EP shall extract data for all patients' records unless the EP is expressly permitted to extract data from patient records maintained using EHR technology.	Numerator and Denominator	N = a positive whole number where N≤D D= a positive whole number where D≥N
MUCP0036 Exclusion	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies), upon request.	EXCLUSION: Any EP that has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period. ATTEST: No requests from patients or their agents were received for an electronic copy of the discharge instructions during the EHR reporting period.	Yes/No	If “Yes”, then MUCP0036 must have N=0; D=0 If the exclusion is indicated “Yes”, the EP must attest.

Meaningful Use Number/ Objective Number	Stage 1 EP Meaningful Use CORE Objectives	Measures	Method of Measure	Logic
MUCP0037	Provide clinical summaries for patients for each office visit.	Clinical summaries provided to patients for more than 50 percent of all office visits within 3 business days.	Numerator and Denominator	N = a positive whole number where N≤D D= a positive whole number where D≥N
MUCP0037 Exclusion	Provide clinical summaries for patients for each office visit.	EXCLUSION: Any EP who has no office visits during the EHR reporting period. ATTEST: No office visits occurred during the EHR reporting period.	Yes/No	If "Yes", then MUCP0037 must have N=0; D=0 If the exclusion is indicated "Yes", the EP must attest.
MUCP0038	Capability to exchange key clinical information (for example, problem list, medication list, allergies, diagnostic test results), among providers of care and patient authorized entities electronically.	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information.	Yes/No	Checkbox to indicate one of the following: yes no

Meaningful Use Number/ Objective Number	Stage 1 EP Meaningful Use CORE Objectives	Measures	Method of Measure	Logic
MUCP0039	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis per 45 CFR 164.308 (a) (1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.	Yes/No	Checkbox to indicate one of the following: yes no

14.2.1.2 Meaningful Use Menu Objectives

Meaningful Use Number/ Objective Number	Stage 1 EP Meaningful Use MENU Objectives	Measure	Method of Measure	Logic
MUMP0040	Implement drug formulary checks	The EP has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period.	Yes/No or Defer	Checkbox to indicate one of the following: yes no defer
MUMP0040 Exclusion	Implement drug formulary checks	EXCLUSION: Any EP who writes fewer than 100 prescriptions during the EHR reporting period. ATTEST: Fewer than 100 prescriptions were written during the EHR reporting period.	Yes/No	If “Yes”, then MUMP0040 must have N<=D; D<100 If the exclusion is indicated “Yes”, the EP must attest.

Meaningful Use Number/ Objective Number	Stage 1 EP Meaningful Use MENU Objectives	Measure	Method of Measure	Logic
MUMP0041	Incorporate clinical lab-test results into EHR as structured data.	More than 40 percent of all clinical lab tests results ordered by the EP during the EHR reporting period whose results are in either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data. EXCLUSION: An EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period. ATTEST: No lab tests were ordered whose results were either in a positive/negative or numeric format during the EHR reporting period.	Numerator and Denominator or Defer	N = a positive whole number where N≤D D= a positive whole number where D≥N
MUMP0041 Exclusion	Incorporate clinical lab-test results into EHR as structured data.	EXCLUSION: An EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period. ATTEST: No lab tests were ordered whose results were either in a positive/negative or numeric format during the EHR reporting period.	Yes/No	If “Yes”, then MUMP0041 must have N=0 and D=0. If the exclusion is indicated “Yes”, the EP must attest.

Meaningful Use Number/ Objective Number	Stage 1 EP Meaningful Use MENU Objectives	Measure	Method of Measure	Logic
MUMP0042	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach.	Generate at least one report listing patients of the EP with a specific condition. PATIENT RECORDS: To meet an objective and its associated measure an EP shall extract data for all patients' records unless the EP is expressly permitted to extract data from patient records maintained using EHR technology.	Yes/ No or Defer	Checkbox to indicate one of the following: yes no defer
MUMP0043	Send reminders to patients per patient preference for preventive/follow up care	More than 20 percent of all unique patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period. PATIENT RECORDS: To meet an objective and its associated measure an EP shall extract data for all patients' records unless the EP is expressly permitted to extract data from patient records maintained using EHR technology.	Numerator and Denominator or Defer	N = a positive whole number where N≤D D= a positive whole number where D≥N Deferral checkbox If defer, N=0 and D=0.

Meaningful Use Number/ Objective Number	Stage 1 EP Meaningful Use MENU Objectives	Measure	Method of Measure	Logic
MUMP0043 Exclusion	Send reminders to patients per patient preference for preventive/follow up care	EXCLUSION: An EP who has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology. ATTEST: I have no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology.	Yes/No	If "Yes", then MUMP0043 must have N=0, D=0. If the exclusion is indicated "Yes", the EP must attest.
MUMP0044	Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists and allergies) within 4 business days of the information being available to the EP.	At least 10 percent of all unique patients seen by the EP are provided timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information subject to the EP's discretion to withhold certain information. PATIENT RECORDS: To meet an objective and its associated measure an EP shall extract data for all patients' records unless the EP is expressly permitted to extract data from patient records maintained using EHR technology.	Numerator and Denominator or Defer	N = a positive whole number where N≤D D= a positive whole number where D≥N Deferral checkbox If defer, N=0 and D=0.

Meaningful Use Number/ Objective Number	Stage 1 EP Meaningful Use MENU Objectives	Measure	Method of Measure	Logic
MUMP0044 Exclusion	Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists and allergies) within 4 business days of the information being available to the EP.	EXCLUSION: An EP neither orders nor creates lab test results or information that would be contained in the problem list, medication list and medication allergy list during the EHR reporting period. ATTEST: An EP neither ordered nor created lab test results or information that would be contained in the problem list, medication list and medication allergy list during the EHR reporting period.	Yes/No	If "Yes", then MUMP0044 must have N=0, D=0. If the exclusion is indicated "Yes", the EP must attest.
MUMP0045	Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.	More than 10 percent of all unique patients seen by the EP during the EHR reporting period are provided patient-specific education resources.	Numerator and Denominator or Defer	N = a positive whole number where N≤D D= a positive whole number where D≥N Deferral checkbox If defer, N=0 and D=0.

Meaningful Use Number/ Objective Number	Stage 1 EP Meaningful Use MENU Objectives	Measure	Method of Measure	Logic
MUMP0046	The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.	The EP performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP. PATIENT RECORDS: To meet an objective and its associated measure an EP shall extract data for all patients' records unless the EP is expressly permitted to extract data from patient records maintained using EHR technology.	Numerator and Denominator or Defer	N = a positive whole number where N≤D D= a positive whole number where D≥N Deferral checkbox If defer, N=0 and D=0.
MUMP0046 Exclusion	The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.	EXCLUSION: An EP who was not the recipient of any transitions of care during the EHR reporting period. ATTEST: The EP was not the recipient of any transitions of care during the EHR reporting period.	Yes/No	If “Yes”, then MUMP0046 must have N=0, D=0. If the exclusion is indicated “Yes”, the EP must attest.

Meaningful Use Number/ Objective Number	Stage 1 EP Meaningful Use MENU Objectives	Measure	Method of Measure	Logic
MUMP0047	The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary of care record for each transition of care or referral	The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals. PATIENT RECORDS: To meet an objective and its associated measure an EP shall extract data for all patients' records unless the EP is expressly permitted to extract data from patient records maintained using EHR technology.	Numerator and Denominator or Defer	N = a positive whole number where N≤D D= a positive whole number where D≥N Deferral checkbox If defer, N=0 and D=0.
MUMP0047 Exclusion	The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary of care record for each transition of care or referral	EXCLUSION: An EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period. ATTEST: The EP neither transferred a patient to another setting nor referred a patient to another provider during the EHR reporting period.	Yes/No	If “Yes”, then MUMP0047 must have N=0, D=0. If the exclusion is indicated “Yes”, the EP must attest.

Meaningful Use Number/ Objective Number	Stage 1 EP Meaningful Use MENU Objectives	Measure	Method of Measure	Logic
MUMP0048	Capability to submit electronic data to immunization registries or immunization information systems and actual submission in accordance with applicable law and practice.	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information have the capacity to receive the information electronically).	Yes/No or Defer	Checkbox to indicate one of the following: yes no defer
MUMP0048 Exclusion 1	Capability to submit electronic data to immunization registries or immunization information systems and actual submission in accordance with applicable law and practice.	EXCLUSION: An EP who administers no immunizations during the EHR reporting period ATTEST: I administered no immunizations during the EHR reporting period.	Yes/No	If the EP administered NO immunizations during the EHR reporting period, the first exclusion is checked and an attestation statement is displayed.

Meaningful Use Number/ Objective Number	Stage 1 EP Meaningful Use MENU Objectives	Measure	Method of Measure	Logic
MUMP0048 Exclusion 2	Capability to submit electronic data to immunization registries or immunization information systems and actual submission in accordance with applicable law and practice.	EXCLUSION: An EP where no immunization registry has the capacity to receive the information electronically. ATTEST: No immunization registry has the capacity to receive the information electronically.	Yes/No	The second exclusion does not have to be checked. If the EP administered immunizations, and the registry is unable to receive the data electronically, the second exclusion is checked and the second attestation statement is displayed.
MUMP0049	Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice.	Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an EP submits such information have the capacity to receive the information electronically).	Yes/No or Defer	Checkbox to indicate one of the following: yes no defer

Meaningful Use Number/ Objective Number	Stage 1 EP Meaningful Use MENU Objectives	Measure	Method of Measure	Logic
MUMP0049 Exclusion	Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice.	EXCLUSION: No public health agency to which the EP submits information has the capacity to receive the information electronically. ATTEST: NONE of the public health agencies to which an EP submits such information have the capacity to receive the information electronically during the EHR reporting period.	Yes/No	If the exclusion is indicated "Yes", the EP must attest.

14.2.2 Eligible Professional Clinical Quality Measures

14.2.2.1 Core Clinical Quality Measures

Measure Number/ PQRS Implementation Number	EP Clinical Quality Measures	Measurement	Logic
NQF 0013	Title: Hypertension: Blood Pressure Measurement Description: Percentage of patient visits for patients aged 18 years and older with a diagnosis of hypertension who has been seen for at least 2 office visits, with blood pressure (BP) recorded.	One Numerator, One Denominator, No Exclusions	N ≤ D IF D=0 then N=0
NQF 0028 A/ PQRI 114	Title: Preventive Care and Screening Measure Pair: a. Tobacco Use Assessment, b. Tobacco Cessation Intervention Description: Percentage of patients aged 18 years and older who have been seen for at least 2 office visits who were queried about tobacco use one or more times within 24 months.	One Numerator, One Denominator, No Exclusions	N ≤ D IF D=0 then N=0

NQF 0028 B/ PQRI 114	Title: Preventive Care and Screening Measure Pair: a. Tobacco Use Assessment, b. Tobacco Cessation Intervention Description: Percentage of patients aged 18 years and older identified as tobacco users within the past 24 months and has been seen for at least 2 office visits, who received cessation intervention.)	One Numerator, One Denominator, No Exclusions	N ≤ D IF D=0 then N=0
NQF 0421/ PQRI 128	Title: Adult Weight Screening and Follow-Up Description: Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented.	Two Numerators, Two Denominators, May Report Exclusions	N ≤ D IF D=0 then N=0
NQF 0421/ PQRI 128 Exclusion	Title: Adult Weight Screening and Follow-Up EXCLUSION:		

14.2.2.2 Alternate Core Clinical Quality Measures

Measure Number/ PQRI Implementation Number	EP Clinical Quality Measures	Measurement	Logic

NQF 0024	Title: Weight Assessment and Counseling for Children and Adolescents Description: Percentage of patients 2 -17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.	Three Numerators, Three Denominators, No Exclusions	N ≤ D IF D=0 then N=0
NQF 0041/ PQRI 110	Title: Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old) Description: Percentage of patients aged 50 years and older who received an influenza immunization during the flu season (September through February).	One Numerator, One Denominator, May Report Exclusions	N ≤ D IF D=0 then N=0
NQF 0041/ PQRI 110	Title: Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old) EXCLUSION:		

NQF 0038	Title: Childhood Immunization Status Description: Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); two H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.	Twelve numerators, Twelve Denominators, No Exclusions	N ≤ D IF D=0 then N=0

14.2.2.3 Additional Other Clinical Quality Measures

Measure Number/ PQRI Implementation Number	EP Clinical Quality Measures	Measurement	Logic
NQF 0059/ PQRI 1	Title: Diabetes: Hemoglobin A1c Poor Control Description: Percentage of patients 18 - 75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c > 9.0%.	One Numerator, One Denominator, May Report Exclusions	N ≤ D IF D=0 then N=0
NQF 0059/ PQRI 1 Exclusion	Title: Diabetes: Hemoglobin A1c Poor Control EXCLUSION:		
NQF 0064/ PQRI 2	Title: Diabetes: Low Density Lipoprotein (LDL) Management and Control Description: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had LDL-C < 100 mg/dL).	Two Numerators, Two Denominators, May Report Exclusions	N ≤ D IF D=0 then N=0
NQF 0064/ PQRI 2 Exclusion	Title: Diabetes: Low Density Lipoprotein (LDL) Management and Control EXCLUSION:		

NQF 0061/ PQRI 3	Title: Diabetes: Blood Pressure Management Description: Percentage of patients 18 - 75 years of age with diabetes (type 1 or type 2) who had blood pressure <140/90 mmHg.	One Numerator, One Denominator, May Report Exclusions	N ≤ D IF D=0 then N=0
NQF 0061/ PQRI 3 Exclusion	Title: Diabetes: Blood Pressure Management EXCLUSION:		
NQF 0081/ PQRI 5	Title: Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD) Description: Percentage of patients aged 18 years and older with a diagnosis of heart failure and LVSD (LVEF < 40%) who were prescribed ACE inhibitor or ARB therapy.	One Numerator, One Denominator, May Report Exclusions	N ≤ D IF D=0 then N=0
NQF 0081/ PQRI 5 Exclusion	Title: Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD) EXCLUSION:		

NQF 0070/ PQRI 7	Title: Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI) Description: Percentage of patients aged 18 years and older with a diagnosis of CAD and prior MI who were prescribed beta-blocker therapy.	One Numerator, One Denominator, May Report Exclusions	N ≤ D IF D=0 then N=0
NQF 0070/ PQRI 7 Exclusion	Title: Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI) EXCLUSION:		
NQF 0043/ PQRI 111	Title: Pneumonia Vaccination Status for Older Adult Description: Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.	One Numerator, One Denominator, No exclusions	N ≤ D IF D=0 then N=0
NQF 0031/ PQRI 112	Title: Breast Cancer Screening Description: Percentage of women 40-69 years of age who had a mammogram to screen for breast cancer.	One Numerator, One Denominator, No exclusions	N ≤ D IF D=0 then N=0

NQF 0034/ PQRI 113	Title: Colorectal Cancer Screening Description: Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.	One Numerator, One Denominator, May Report Exclusions	N ≤ D IF D=0 then N=0
NQF 0034/ PQRI 113 Exclusion	Title: Colorectal Cancer Screening EXCLUSION:		
NQF 0067/ PQRI 6	Title: Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD Description: Percentage of patients aged 18 years and older with a diagnosis of CAD who was prescribed oral antiplatelet therapy.	One Numerator, One Denominator, May Report Exclusions	N ≤ D IF D=0 then N=0
NQF 0067/ PQRI 6 Exclusion	Title: Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD EXCLUSION:		

NQF 0083/ PQRI 8	Title: Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD) Description: Percentage of patients aged 18 years and older with a diagnosis of heart failure who also have LVSD (LVEF < 40%) and who were prescribed beta-blocker therapy.	One Numerator, One Denominator, May Report Exclusions	N ≤ D IF D=0 then N=0
NQF 0083/ PQRI 8 Exclusion	Title: Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD) EXCLUSION:		
NQF 0086/ PQRI 12	Title: Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation Description: Percentage of patients aged 18 years and older with a diagnosis of POAG who have been seen for at least two office visits who have an optic nerve head evaluation during one or more office visits within 12 months.	One Numerator, One Denominator, May Report Exclusions	N ≤ D IF D=0 then N=0
NQF 0086/ PQRI 12 Exclusion	Title: Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation EXCLUSION:		

NQF 0088/ PQRI 18	Title: Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy Description: Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy and the presence or absence of macular edema during one or more office visits within 12 months.	One Numerator, One Denominator, May Report Exclusions	N ≤ D IF D=0 then N=0
NQF 0088/ PQRI 18 Exclusion	Title: Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy EXCLUSION:		
NQF 0089/ PQRI 19	Title: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care Description: Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months. One Numerator, One Denominator, May Report Exclusions	One Numerator, One Denominator, May Report Exclusions	N ≤ D IF D=0 then N=0

NQF 0089/ PQRI 19 Exclusion	Title: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care EXCLUSION:		
NQF 0047/ PQRI 53	Title: Asthma Pharmacologic Therapy Description: Percentage of patients aged 5 through 40 years with a diagnosis of mild, moderate, or severe persistent asthma who were prescribed either the preferred long-term control medication (inhaled corticosteroid) or an acceptable alternative treatment.	One Numerator, One Denominator, May Report Exclusions	N ≤ D IF D=0 then N=0
NQF 0047/ PQRI 53 Exclusion	Title: Asthma Pharmacologic Therapy EXCLUSION:		
NQF 0001/ PQRI 64	Title: Asthma Assessment Description: Percentage of patients aged 5 through 40 years with a diagnosis of asthma and who have been seen for at least 2 office visits, which were evaluated during at least one office visit within 12 months for the frequency (numeric) of daytime and nocturnal asthma symptoms.	One Numerator, One Denominator, No Exclusions	N ≤ D IF D=0 then N=0

NQF 0002/ PQRI 66	Title: Appropriate Testing for Children with Pharyngitis Description: Percentage of children 2-18 years of age, who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode.	One Numerator, One Denominator, No Exclusions	N ≤ D IF D=0 then N=0
NQF 0387/ PQRI 71	Title: Oncology Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer Description: Percentage of female patients aged 18 years and older with Stage IC through IIIC, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period.	One Numerator, One Denominator, May Report Exclusions	N ≤ D IF D=0 then N=0
NQF 0387/ PQRI 71 Exclusion	Title: Oncology Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer EXCLUSION:		

NQF 0385/ PQRI 72	Title: Oncology Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients Description: Percentage of patients aged 18 years and older with Stage IIIA through IIIC colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy within the 12-month reporting period.	One Numerator, One Denominator, May Report Exclusions	N ≤ D IF D=0 then N=0
NQF 0385/ PQRI 72 Exclusion	Title: Oncology Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients EXCLUSION:		
NQF 0389/ PQRI 102	Title: Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients Description: Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer.	One Numerator, One Denominator, May Report Exclusions	N ≤ D IF D=0 then N=0
NQF 0389/ PQRI 102 Exclusion	Title: Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients EXCLUSION:		

NQF 0027/ PQRI 115	Title: Smoking and Tobacco Use Cessation, Medical assistance: a. Advising Smokers and Tobacco Users to Quit, b. Discussing Smoking and Tobacco Use Cessation Medications, c. Discussing Smoking and Tobacco Use Cessation Strategies Description: Percentage of patients 18 years of age and older who were current smokers or tobacco users, who were seen by a practitioner during the measurement year and who received advice to quit smoking or tobacco use or whose practitioner recommended or discussed smoking or tobacco use cessation medications, methods or strategies.	Two Numerators, Two Denominators, No Exclusions	N ≤ D IF D=0 then N=0 Must report both parts of measure A and B
NQF 0055/ PQRI 117	Title: Diabetes: Eye Exam Description: Percentage of patients 18 -75 years of age with diabetes (type 1 or type 2) who had a retinal or dilated eye exam or a negative retinal exam (no evidence of retinopathy) by an eye care professional.	One Numerator, One Denominator, May Report Exclusions	N ≤ D IF D=0 then N=0
NQF 0055/ PQRI 117 Exclusion	Title: Diabetes: Eye Exam EXCLUSION:		
NQF 0062/ PQRI 119	Title: Diabetes: Urine Screening Description: Percentage of patients 18 - 75 years of age with diabetes (type 1 or type 2) who had a nephropathy screening test or evidence of nephropathy.	One Numerator, One Denominator, May Report Exclusions	N ≤ D IF D=0 then N=0

NQF 0062/ PQRI 119 Exclusion	Title: Diabetes: Urine Screening EXCLUSION:		
NQF 0056/ PQRI 163	Title: Diabetes: Foot Exam Description: The percentage of patients aged 18 - 75 years with diabetes (type 1 or type 2) who had a foot exam (visual inspection, sensory exam with monofilament, or pulse exam).	One Numerator, One Denominator, May Report Exclusions	N ≤ D IF D=0 then N=0
NQF 0056/ PQRI 163 Exclusion	Title: Diabetes: Foot Exam EXCLUSION:		
NQF 0074/ PQRI 197	Title: Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol Description: Percentage of patients aged 18 years and older with a diagnosis of CAD who was prescribed a lipid-lowering therapy (based on current ACC/AHA guidelines).	One Numerator, One Denominator, May Report Exclusions	N ≤ D IF D=0 then N=0
NQF 0074/ PQRI 197 Exclusion	Title: Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol EXCLUSION:		

NQF 0084/ PQRI 200	Title: Heart Failure (HF): Warfarin Therapy Patients with Atrial Fibrillation Description: Percentage of all patients aged 18 years and older with a diagnosis of heart failure and paroxysmal or chronic atrial fibrillation that were prescribed warfarin therapy.	One Numerator, One Denominator, May Report Exclusions	N ≤ D IF D=0 then N=0
NQF 0084/ PQRI 200 Exclusion	Title: Heart Failure (HF): Warfarin Therapy Patients with Atrial Fibrillation EXCLUSION:		
NQF 0073/ PQRI 201	Title: Ischemic Vascular Disease (IVD): Blood Pressure Management Description: Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1- November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and whose recent blood pressure is in control (<140/90 mmHg).	One Numerator, One Denominator, No Exclusions	N ≤ D IF D=0 then N=0

NQF 0068/ PQRI 204	Title: Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic Description: Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1-November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and who had documentation of use of aspirin or another antithrombotic during the measurement year.	One Numerator, One Denominator, No Exclusions	N ≤ D IF D=0 then N=0
NQF 0012	Title: Prenatal Care: Screening for Human Immunodeficiency Virus (HIV) Description: Percentage of patients, regardless of age, who gave birth during a 12-month period who were screened for HIV infection during the first or second prenatal care visit.	One Numerator, One Denominator, May Report Exclusions	N ≤ D IF D=0 then N=0
NQF 0012 Exclusion	Title: Prenatal Care: Screening for Human Immunodeficiency Virus (HIV) EXCLUSION:		

NQF 0014	Title: Prenatal Care: Anti-D Immune Globulin Description: Percentage of D (Rh) negative, unsensitized patients, regardless of age, who gave birth during a 12-month period who received anti-D immune globulin at 26-30 weeks gestation.	One Numerator, One Denominator, May Report Exclusions	N ≤ D IF D=0 then N=0
NQF 0014 Exclusion	Title: Prenatal Care: Anti-D Immune Globulin EXCLUSION:		
NQF 0018	Title: Controlling High Blood Pressure Description: The percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled during the measurement year.	One Numerator, One Denominator, No Exclusions	N ≤ D IF D=0 then N=0
NQF 0032	Title: Cervical Cancer Screening Description: Percentage of women 21-64 years of age, who received one or more Pap tests to screen for cervical cancer.	One Numerator, One Denominator, No Exclusions	N ≤ D IF D=0 then N=0

NQF 0033	Title: Chlamydia Screening for Women Description: Percentage of women 15- 24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.	Three Numerators, Three Denominators, May Report Exclusions	N ≤ D IF D=0 then N=0
NQF 0033 Exclusion	Title: Chlamydia Screening for Women EXCLUSION:		
NQF 0036	Title: Use of Appropriate Medications for Asthma Description: Percentage of patients 5 - 50 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement year. Report three age stratifications (5-11 years, 12-50 years, and total).	Three Numerators, Three Denominators, May Report Exclusions	N ≤ D IF D=0 then N=0
NQF 0036 Exclusion	Title: Use of Appropriate Medications for Asthma EXCLUSION:		
NQF 0052	Title: Low Back Pain: Use of Imaging Studies Description: Percentage of patients with a primary diagnosis of low back pain who did not have an imaging study (plain x-ray, MRI, CT scan) within 28 days of diagnosis.	One Numerator, One Denominator, No Exclusions	N ≤ D IF D=0 then N=0

NQF 0075	Title: Ischemic Vascular Disease (IVD): Complete Lipid Profile and LDL Control Description: Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal angioplasty (PTCA) from January 1-November1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and who had a complete lipid profile performed during the measurement year and whose LDL-C<100 mg/dL.	Two Numerators, Two Denominators, No Exclusions	N ≤ D IF D=0 then N=0
NQF 0575	Title: Diabetes: Hemoglobin A1c Control (<8.0%) Description: The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c <8.0%.	One Numerator, One Denominator, May Report Exclusions	N ≤ D IF D=0 then N=0
NQF 0575 Exclusion	Title: Diabetes: Hemoglobin A1c Control (<8.0%) EXCLUSION:		

NQF 0004	Title: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: a) Initiation, b) Engagement Description: Percentage of adolescent and adult patients with a new episode of alcohol and other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis and who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.	Six Numerators, Six Denominators, No Exclusions	N ≤ D IF D=0 then N=0
NQF 0105	Title: Anti-depressant medication management: (a) Effective Acute Phase Treatment, (b) Effective Continuation Phase Treatment Description: Percentage of patients 18 years of age and older who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication treatment.	Two Numerators, Two Denominators, No Exclusions	N ≤ D IF D=0 then N=0


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